



SCOTT & WHITE
HEALTH PLAN

HEALTH CARE

EVIDENCE OF COVERAGE

THIS HEALTH CARE EVIDENCE OF COVERAGE IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

Corporate Office
2401 South 31st Street
Temple, Texas 76508
(254) 298-3000
(800) 321-7947



CERTIFICATE OF COVERAGE

In consideration of the completed and accepted Enrollment Application and timely payment of the required payments, Scott and White Health Plan agrees to provide or arrange to provide the benefits specified in this Agreement, in accordance with and subject to the terms stated herein and all applicable local, state and federal laws. This Agreement, application, forms and any attachments to them form the entire contract.

In consideration of the Health Plan's Agreement to provide those Health Care Services specified in this Agreement and subject to the terms stated herein, You and the Contract Holder promise to pay all required payments when due, abide by all of the terms of this Agreement and comply with all applicable local, state and federal laws.

Important Notices:

1. The initial rates agreed upon by Group and Scott and White Health Plan are effective during the initial year from and after the effective date of this Agreement. Thereafter, Health Plan reserves the right to change rates upon 60 days notice prior to renewal.
2. The coverage provided under this Agreement is health maintenance organization (HMO) coverage and not indemnity insurance. As an HMO, the Health Plan contracts with only certain providers; therefore, with certain exceptions as explained herein, You and Your Covered Dependents are required to use those providers in order to receive the coverage described. Those providers shall determine the methods used and the form of Treatment to be provided. The Health Plan does not intend that all alternative forms and methods of Treatment will be eligible for coverage. If You or Your Covered Dependents elect to receive Treatment from a non-Health Plan provider, or receive a form of Treatment not authorized by the Health Plan, You may be required to pay for the services provided out of your own pocket.
3. Scott and White Health Plan is a named fiduciary to review claims under this Agreement. Group delegates to Health Plan the discretion to determine whether You and Your Covered Dependents are entitled to the benefits of this Agreement. In making these determinations, Health Plan has the authority to review claims in accord with the procedures contained herein and to construe this Agreement to determine if You and Your Covered Dependents are entitled to its benefits. If Group is subject to the Employee Retirement Income Security Act, a federal law, this Agreement may be governed by the provisions of that law.

In witness whereof Scott and White Health Plan has caused this Health Care Agreement to be executed as of the Effective Date.



Chief Executive Officer
Scott and White Health Plan
2401 South 31st Street
Temple, Texas 76508

Summary of HMO Benefits for Plan Year 2009

Benefit Description	Member's Copayment PY 2009
<i>Physicians and Lab Services</i>	
Physician Office Visit Primary Care Physician	\$30
Specialist Office Visit	\$40
Routine physicals-One per plan year for adults; periodic for children, or as directed by the primary care physician	\$30 or \$40
Diagnostic x-rays, mammography, and lab tests	No copayment
Immunizations - For Children 0 to 6 years of age	No copayment
Immunizations - For Children 7 years and older, and adults	\$30
Well woman exam - One per plan year	\$30 or \$40
Vision, speech, and hearing screenings -For all enrolled participants	\$40
Speech & hearing testing (covered for all participants)	\$40
Speech therapy and rehabilitative therapy, including physical and occupational therapy-Covered as any other illness and not subject to any maximum	\$40
Allergy testing	\$40
Allergy serum	50%
Allergy serum administration-When allergy shot is administered without an office visit	No copayment
Routine eye exam-one per plan year	\$40
Office surgery & procedures (all office surgeries, excluding vasectomies and tubal ligations)	\$30 or \$40
Maternity care-Physician services, including diagnosis of pregnancy, pre- & post-natal care, and delivery (including delivery by C-section) – see “Hospital Services” for Inpatient charges	No copayment
Family planning	\$40
Vasectomy & tubal ligation	No copayment
Infertility benefits	50%
<i>Hospital Services</i>	
Inpatient hospital-Semi-private room & board or intensive care units	\$100 per day copayment per admission, 5 day max. \$1500 max. per person per year
Outpatient day surgery	\$100
Other inpatient charges, including medically necessary surgical procedures. Includes orthognathic surgery. Guest trays, cots, telephone, maternity kits, paternity kits, and other personal items not covered	No copayment
Blood and blood products-Inpatient & outpatient	No copayment
Private Duty Nursing, based on medical necessity	No copayment
Outpatient facilities, including pre-admission testing and/or treatment room	No copayment

Benefit Description	Member's Copayment PY 2009
Emergency care - In-area and out-of-area covered at listed copayment. If hospitalized, copayment is waived	\$100
Urgent care - Includes physician's after-hours care or at an urgent care facility	\$50
<i>Extended Care Services (Based on medical necessity)</i>	
Skilled Nursing facility - covered up to 60 days per plan year	No copayment
Hospice Care-inpatient and outpatient	No copayment
Home health	No copayment
Private duty nursing	No copayment
<i>Other Medical Services</i>	
Hearing aids - \$500.00 per ear every 3 years (Repairs not covered)	Plan pays \$500 per ear every 3 years
Hearing aid batteries - Not subject to any maximum amounts	No copayment
Dental - Restoration & correction of damage caused by external violent accidental injury to healthy, natural teeth, occurring while covered under the plan for services provided within 24 months of the date of the accident. Certain oral surgeries are covered	\$40
Durable Medical Equipment - Includes medically necessary purchase and/or rental. Benefits for rental are limited to, and will not exceed, the purchase price of the equipment. (Repairs are covered if not due to neglect or abuse.) This benefit also includes diabetic supplies other than insulin, diabetic oral agent(s), and syringes as specified in Section 1358.051(2), Tex. Ins. Code	20%
Prostheses - Artificial devices, surgical or non-surgical, which replace body parts, including arms, legs, eyes and cochlear implants are covered. Replacements and repairs are covered as required by medical necessity.	20%
Organ Transplants - Covered as any other illness for kidney, cornea, liver, heart, heart-lung, lung, pancreatic-kidney, bone marrow, and other organ transplants that the HMO determines to be not experimental and/or not investigational according to current medical plan guidelines. Donor expenses are covered. Artificial organs (e.g. heart) not covered	No copayment (Hospital copayments will apply)
Ambulance - professional local ground or air ambulance transportation services to the nearest hospital, appropriately equipped and staffed for the treatment of the participant's condition	No copayment
<i>Behavioral Health</i>	
Inpatient mental health-Covered in full up to 30 days per plan year	\$100 per day copayment per admission, 5 day max. \$1500 max. per person per year
Inpatient serious mental illness-Covered as any other illness	\$100 per day copayment per admission, 5 day max. \$1500 max. per person per year
Inpatient chemical dependency-Covered as any other illness, based on medical necessity	\$100 per day copayment per admission, 5 day max. \$1500 max. per person per year
Outpatient mental health-25 visits per plan year	\$40
Outpatient serious mental illness-Covered as any other illness	\$40
Outpatient chemical dependency-Same as any other illness and not subject to any maximums	\$40

Benefit Description	Member's Copayment PY 2009
Prescription Drugs Plan Year Deductible (per member per plan year)	\$50
If a Brand Name medication is dispensed when a Generic is available, member shall be responsible for the Generic Copayment plus the cost difference between the Generic and the Brand Name medication	
Participating Retail Pharmacy-Tier 1, Tier 2 & Tier 3	
Up to a 30-day supply per prescription or refill of Non-Maintenance medication	\$10/\$25/\$40
Up to a 30-day supply per prescription or refill of Maintenance medication	\$15/\$35/\$55
Infertility drugs are paid at 50% copayment	50%
Up to a 30-day supply of insulin for one copayment	\$10/\$25/\$40
Up to a 30-day supply of each diabetic oral agent for one copayment	\$10/\$25/\$40
The supply of necessary disposable syringes for the insulin supply for one copayment	\$25
This benefit also includes diabetic supplies other than insulin, diabetic oral agent(s), and syringes as specified in Section 1358.051(2), Tex. Ins. Code. Up to a 30-day supply for a 20% copayment	20%
Mail Order Pharmacy-Tier 1, Tier 2 & Tier 3	
Up to a 90-day supply per prescription or refill for one mail order copayment	\$30/\$75/\$120
Oral contraceptives up to a 90-day supply for one mail order copayment	\$30/\$75/\$120
Infertility drugs are paid at 50% copayment	50%
Up to a 90-day supply of insulin for one mail order copayment	\$30/\$75/\$120
Up to a 90-day supply of each diabetic oral agent for one mail order copayment	\$30/\$75/\$120
The supply of necessary disposable syringes for the insulin supply for one mail order copayment	\$75
This benefit also includes diabetic supplies other than insulin, diabetic oral agent(s), and syringes as specified in Section 1358.051(2), Tex. Ins. Code. Up to a 90-day supply for a 20% copayment	20%

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Scott and White Health Plan's toll-free telephone numbers for information or to make a complaint at

LOCAL/LONG DISTANCE NUMBERS

Temple	Bryan/College Station
(254) 298-3000	(979) 268-7947
(800) 321-7947	(800) 791-8777

Georgetown	Waco
(512) 930-6040	(254) 756-8000
(800) 758-3012	(800) 684-7947

You may also write to Scott and White Health Plan at:

2401 South 31st Street
Temple, TX 76508

You may contact the Texas Department of Insurance to obtain information on companies, coverage, rights or complaints at

1-800-252-3439

You may write the Texas Department of Insurance

P.O. Box 149104
Austin, TX 78714-9104
FAX: (512) 475-1771

Email:

ConsumerProtection@tdi.state.tx.us

Web: <http://www.tdi.state.tx.us>

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim you should contact the Scott and White Health Plan first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY:

This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numeros de telefono gratis de la Scott and White Health Plan's para informacion o para someter una queja al

NUMEROS LOCALES/DE LARGA DISTANCIA

Temple	Bryan/College Station
(254) 298-3000	(979) 268-7947
(800) 321-7947	(800) 791-8777

Georgetown	Waco
(512) 930-6040	(254) 756-8000
(800) 758-3012	(800) 684-7947

Usted tambien puede escribir a la Scott and White Health Plan

2401 South 31st Street
Temple, TX 76508

Puede comunicarse con el Departamento de seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas

P.O. Box 149104
Austin, TX 78714-9104
FAX # (512) 475-1771

Email:

ConsumerProtection@tdi.state.tx.us

Web: <http://www.tdi.state.tx.us>

DISPUTAS SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el Scott and White Health Plan primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA:

Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

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1. DEFINITIONS

The following terms shall have the meaning stated. The various attachments to this Evidence of Coverage may contain additional definitions which pertain to the Health Care Services set forth in this Agreement. Capitalized words are defined terms throughout this Agreement.

1.1 “**Acquired Brain Injury**” means a neurological insult to the brain, which is not hereditary, congenital, or degenerative, in which the injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.

1.2 “**Adverse Determination**” means a determination by Health Plan that the Health Care Services furnished or proposed to be furnished to a member are not medically necessary as defined in this Evidence of Coverage.

1.3 “**Age of Ineligibility**” means the age at which dependents are no longer eligible for coverage, subject to the definition of Eligible Dependent. Unless amended by Your Group, Age of Ineligibility will be 25.

1.4 “**Agreement**” means this Scott and White Health Plan evidence of coverage and all attachments and riders herein.

1.5 “**Appeal**” is an oral or written request for Health Plan to reverse a previous decision.

1.6 “**Chemical Dependency**” means the abuse of, psychological or physical dependence on, or addiction to alcohol or a controlled substance.

1.7 “**Chemical Dependency Treatment Center**” means a facility which is a Participating Provider and, which provides a program for the Treatment of chemical dependency pursuant to a written Treatment plan approved and monitored by a Participating Physician and which facility is also:

- 1) affiliated with a hospital under a contractual agreement with an established system for patient referral; or
- 2) accredited as a chemical dependency treatment center by the Joint Commission on Accreditation of Health Care Organizations; or
- 3) licensed as a chemical dependency treatment program by the Texas Commission on Alcohol and Drug Abuse; or
- 4) licensed, certified, or approved as a chemical dependency treatment program or center by any other agency of the State of Texas having legal authority to so license, certify, or approve.

1.8 “**Cognitive communication therapy**” means services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.

1.9 “**Cognitive rehabilitation therapy**” means services designed to address therapeutic cognitive activities, based on an assessment and understanding of a Member’s brain-behavioral deficits.

1.10 “**Community reintegration services**” means services that facilitate the continuum of care as an affected Member transitions into the community.

1.11 “**Complainant**” means a member, or a physician, provider, or other person designated to act on behalf of a member, who files a complaint.

1.12 “**Complaint**” is any oral or written expression of dissatisfaction with any aspect of Health Plan’s operation, including but not limited to dissatisfaction with plan administration; procedures related to review or appeal of an adverse determination; the denial, reduction, or termination of a service for reasons not related to medical necessity; the way a service is provided; or disenrollment decisions expressed by a Complainant. The term does not include a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information. The term does not include dissatisfaction or disagreement with an adverse determination.

1.13 “**Contract Date**” means the date on which coverage for Your Employer’s Health Benefit Plan commences.

1.14 “**Contract Holder**” means the person or entity with whom the Health Plan has entered into an agreement to provide health care services. Under this evidence of coverage, the Group is the Contract Holder.

1.15 “**Contract Year**” means that period of time which begins at 12:00 midnight on the Contract Date and ends at 12:00 midnight one year later.

1.16 “**Controlled Substance**” means a toxic inhalant or a substance designated as a controlled substance in the Texas Controlled Substances Act (Chapter 481 of Texas Health and Safety Code).

1.17 “**Copayment**” means the dollar amount or the percentage of the cost of Health Care Services, if any, shown in the Schedule of Benefits payable by the Member to a Participating Hospital, Participating Physician, or Participating Provider, when Health Care Services are obtained from that Participating Hospital, Participating Physician, or Participating Provider.

1.18 **“Covered Dependent”** means a member of Your family who meets the eligibility provisions as specified in Section 2 of this Agreement.

1.19 **“Creditable Coverage”** means any group health coverage or individual health coverage, including services from insurance or a health maintenance organization, that qualifies under regulations implementing the Federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), provided such coverage ended within the sixty-three (63) day period directly preceding the applicant’s request to enroll in this Plan.

1.20 **“Crisis Stabilization Unit”** means an appropriately-licensed and accredited 24-hour residential program that is usually short-term in nature that provides intensive supervision and highly structured activities to Members who are demonstrating an acute demonstrable psychiatric crisis of moderate to severe proportions.

1.21 **“Custodial Care”** means care designed principally to assist an individual in engaging in the activities of daily living, or services which constitute personal care, such as help in walking and getting in and out of bed; assistance in bathing, dressing, feeding and using the toilet; preparation of special diets; and supervision of medication, which can usually be self-administered and which does not entail or require the continuing attention of trained medical or other paramedical personnel. Custodial Care is normally, but not necessarily, provided in a nursing home, convalescent home, or rest home or similar institution.

1.22 **“Deductible”** means the dollar amount, if any, shown in the Schedule of Benefits payable by the Member for Health Care Services before benefits under the Health Care Plan will be payable.

1.23 **“Diabetic Equipment”** means blood glucose monitors, including those designed to be used by blind individuals, insulin pumps and associated attachments, insulin infusion devices, and podiatric appliances for the prevention of diabetic complications.

1.24 **“Diabetic Self-Management Training”** means any of the following training or instruction provided by a Participating Physician or Participating Provider following initial diagnosis of diabetes: instruction in the care and management of the condition, nutritional counseling, counseling in the proper use of diabetic equipment and supplies, subsequent training or instruction necessitated by a significant change in the Member’s symptoms or condition which impacts the self-management regime, and appropriate periodic or continuing education as warranted by the development of new techniques and treatments for diabetes.

1.25 **“Diabetic Supplies”** means test strips for blood glucose monitors, visual reading and urine test strips, lancets and lancet devices, insulin and insulin analogs, injection

aids, syringes for administering insulin, oral agents available with or without a prescription for controlling blood sugar levels, and glucagon emergency kits.

1.26 **“Effective Date”** means the date the coverage for You or Your Covered Dependent actually begins as specified in Section 2 of this Agreement.

1.27 **“Eligible Employee”** means an employee as specified in Section 2 of this Agreement.

1.28 **“Eligibility Date”** means the date the Member satisfies the definition, of either Eligible Employee or Dependent and is in a class eligible for coverage under the Health Plan as specified in Section 2 of this Agreement.

1.29 **“Emergency Care”** shall mean Health Care Services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- 1) placing his or her health in serious jeopardy;
- 2) serious impairment to bodily functions;
- 3) serious dysfunction of any bodily organ or part;
- 4) serious disfigurement; or
- 5) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

1.30 **“Employer”** means Group.

1.31 **“Enrollment Application”** means any document(s) which must be completed by or on behalf of a person in applying for coverage.

1.32 **“Experimental” or “Investigational”** means, in the opinion of the Medical Director, Treatment that has not been proven successful in improving the health of patients. In making such determinations, the Medical Director will rely upon:

- 1) Well-designed and well conducted investigations published in recognized peer reviewed medical literature, such as the New England Journal of Medicine or the Journal of Clinical Oncology, when such papers report conclusive findings of controlled or randomized trials. The Medical Director shall consider the quality of the body of studies and the consistency of the results in evaluating the evidence;
- 2) Communications about the Treatment that have been provided to patients as part of an informed consent;
- 3) Communications about the procedure or Treatment that have been provided from the physician undertaking a study of the Treatment to the institution or government sponsoring the study;

- 4) Documents or records from the institutional review board of the hospital or institution undertaking a study of the Treatment;
- 5) Regulations and other communications and publications issued by the Food and Drug Administration and the Department of Health and Human Services; and
- 6) the Member's medical records.

As used above, "peer reviewed medical literature" means one or more U. S. scientific publications which require that manuscripts be submitted to acknowledged experts inside or outside the editorial office for their considered opinions or recommendations regarding publication of the manuscript. In addition, in order to qualify as peer reviewed medical literature, the manuscript must actually have been reviewed by acknowledged experts before publication.

Treatments referred to as "experimental", "experimental trial", "investigational", "investigational trial", "trial", "study", "controlled study", "controlled trial", and any other term of similar meaning shall be considered to be Experimental or Investigational.

1.33 "**Group**" means Employees Retirement System of Texas.

1.34 "**Health Benefit Plan**" means a group, blanket, or franchise insurance policy, a certificate issued under a group policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a health maintenance organization that provides benefits for health care services.

1.35 "**Health Care Services**" means those Medically Necessary services which are included in the Description of Benefits and any amendments or riders thereto, and which are performed, prescribed or authorized by a Participating Physician, Participating Provider, Participating Hospital or a Referral Physician.

1.36 "**Health Plan**" means Scott and White Health Plan.

1.37 "**Health Professionals**" means those health care professionals, licensed in the State of Texas (or, in the case of Health Care Services rendered on referral, licensed in the State in which that care is provided) who are associated with, or engaged by, directly or indirectly, Health Plan or Referral Physicians to provide Health Care Services in the Service Area. "Health Professionals" includes a Doctor of Dentistry, a Doctor of Podiatry, a Doctor of Optometry, a Doctor of Chiropractic, a Doctor in Psychology, Acupuncturists, a Licensed Audiologist, a Licensed Speech-Language Pathologist, a Licensed Hearing Aid Fitter and Dispenser, a Licensed Dietitian, a Licensed Master Social Worker-Advanced Clinical Practitioner, a Licensed Professional Counselor or a Licensed Marriage and Family

Therapist, and other practitioners of the healing arts as specified in the Texas Insurance Code.

1.38 "**Independent Review Organization**" means an organization selected as provided under Section 4202.001 et seq. of the Texas Insurance Code.

1.39 "**Individual Treatment Plan**" means a Treatment plan prepared or approved by the Member's Primary Care Physician with specific attainable goals and objectives appropriate to both the Members and the Treatment modality of the program.

1.40 "**Life-Threatening Condition**" means a disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted.

1.41 "**Medical Director**" means any Physician designated by the Health Plan who shall have such responsibilities for assuring the continuity, availability and accessibility of Health Care Services as shall be assigned. These responsibilities include, but are not limited to, monitoring the programs of quality assurance, utilization review and peer review; determining Medical Necessity; and determining whether or not a Treatment is Experimental or Investigational.

1.42 "**Medically Necessary**" means those Health Care Services which, in the opinion of Member's Primary Care Physician or Referral Physician, whose opinions are subject to the review, approval or disapproval, and actions of the Medical Director or the Quality Assurance Committee in their appointed duties, are:

- 1) essential to preserve the health of Member; and
- 2) consistent with the symptoms or diagnosis and Treatment of the Member's condition, disease, ailment or injury; and
- 3) appropriate with regard to standards of good medical practice within the surrounding community; and
- 4) not solely for the convenience of the Member, Member's Physician, Hospital, or other health care provider; and
- 5) the most appropriate supply or level of service which can be safely provided to the Member.

1.43 "**Medicare**" means Title XVIII of the Social Security Act, and amendments thereto.

1.44 "**Member**" means You or Your Covered Dependent.

1.45 "**Neurobehavioral testing**" means an evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and premorbid history, including the identification of problematic behavior and the relationship between behavior and the variables that

control behavior. This may include interviews of a Member, a Member's family, or others.

1.46 **“Neurobehavioral treatment”** means interventions that focus on behavior and the variables that control behavior.

1.47 **“Neurocognitive rehabilitation”** means services designed to assist cognitively impaired Members to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.

1.48 **“Neurocognitive therapy”** means services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.

1.49 **“Neurofeedback therapy”** means services that utilize operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood.

1.50 **“Neuropsychological testing”** means the administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.

1.51 **“Neuropsychological treatment”** means interventions designed to improve or minimize deficits in behavioral and cognitive processes.

1.52 **“Neurophysiological testing”** means an evaluation of the functions of the nervous system.

1.53 **“Neurophysiological treatment”** means interventions that focus on the functions of the nervous system.

1.54 **“Out-of-Pocket Expenses”** means the portion of Covered Services for which a Member is required to pay at the time services and treatments are received after the Deductible has been met. Out-of-Pocket Expenses apply to Covered Services only. Medical services and treatments, which are not covered by this Plan or are not Medically Necessary, are not included in determining Out-of-Pocket Expenses.

1.55 **“Out-of-Pocket Maximum”** means the total dollar amount of Out-of-Pocket Expenses which a Member will be required to pay for Covered Services during a Contract Year after the Deductible has been met. Out-of-Pocket Maximum is determined for Covered Services and not for any medical services or treatments which are not Medically Necessary or not covered.

1.56 **“Out-of-Pocket Maximum, Family”** means the total amount of Out-of-Pocket Expenses which one family will be required to pay in any one Contract Year after the Deductible has been met.

1.57 **“Participating Hospital”** means an institution licensed by the State of Texas as a hospital which has contracted or arranged with Health Plan to provide Health Care Services to Members and which is listed by Health Plan as a Participating Provider.

1.58 **“Participating Physician”** means anyone licensed to practice medicine in the State of Texas and who is employed by or has executed a contract with Health Plan to provide Health Care Services.

1.59 **“Participating Provider”** means any person or entity that has contracted, directly or indirectly, with Health Plan to provide Health Care Services to Members. Participating Providers include but are not limited to: Participating Hospitals, Participating Physicians, Health Professionals, Urgent Care Facilities, and Contracted Pharmacies, within the service area.

1.60 **“Permanent Legal Residence”** means the address at which a Member intends to reside during the Contract Year. For a student enrolled in an education, trade, or technical school, the Permanent Legal Residence is presumed to be that of the parent with whom the Covered Dependent resided prior to attending school.

1.61 **“Post-acute transition services”** means services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.

1.62 **“Postdelivery care”** means postpartum health care services provided in accordance with accepted maternal and neonatal assessments including, but not limited to, parent education, assistance and training in breast-feeding and bottle-feeding, and the performance of any necessary and appropriate clinical tests.

1.63 **“Premium”** means those periodic amounts required to be paid to Health Plan for or on behalf of a Subscriber and Covered Dependents, if any, as a condition of coverage under this Agreement.

1.64 **“Premium Contribution”** means the minimum percentage of premium which Your Employer must pay for Your coverage.

1.65 **“Primary Care Physician”** means a Participating Physician specializing in family medicine, community internal medicine, general medicine, or pediatrics selected by You or Your Covered Dependent to manage the Health Care Services which will be made available to You or Your Covered Dependent by Health Plan.

1.66 “**Psychiatric Day Treatment Facility**” means a mental health facility, licensed by the State of Texas, which provides treatment for individuals suffering from acute, mental and nervous disorders in a structured psychiatric program utilizing individualized treatment plans with specific attainable goals and objectives appropriate both to the patient and the treatment modality of the program and that is clinically supervised by a doctor of medicine who is certified in psychiatry by the American Board of Psychiatry and Neurology. The facility at which the treatment is performed must have a contract with Health Plan to provide its services to Members, must treat its patients not more than eight hours in any twenty-four hour period, and must be accredited by the Program for Psychiatric Facilities, or its successor, of the Joint Commission on Accreditation of Health Care Organizations.

1.67 “**Psychophysiological testing**” means an evaluation of the interrelationships between the nervous system and other bodily organs and behavior.

1.68 “**Psychophysiological treatment**” means interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.

1.69 “**Qualified Medical Support Order**” means an order issued by a Texas Court or enforceable by a Texas Court which sets forth the responsibility for providing health care coverage for eligible Dependents.

1.70 “**Quality Assurance Committee**” means a committee or committees used by the Health Plan to establish programs to monitor the appropriateness and effectiveness of the Health Care Services provided for or arranged by the Health Plan, record the outcome of Treatment, and provide a means for peer review.

1.71 “**Referral Physician**” means a professional person who is licensed to practice medicine in the State where his or her medical services are required to be performed, and to whom in the opinion of the Medical Director and Member's Primary Care Physician it is necessary to refer a Member for a Health Care Service.

1.72 “**Remediation**” means the process(es) of restoring or improving a specific function.

1.73 “**Residential Treatment Center for Children and Adolescents**” means a child-care institution that provides residential care and treatment for emotionally disturbed children and adolescents and that is accredited as a residential treatment center by the Council on Accreditation, the Joint Commission on Accreditation of Healthcare Organizations, or the American Association of Psychiatric Services for Children.

1.74 “**Schedule of Benefits**” means the attachment to this Agreement which describes, among other things, the Copayments, Deductibles, and other information applicable to Your Health Plan and Health Care Services set forth in the Description of Benefits attachment to this agreement and any amendments or riders thereto.

1.75 “**Series of Treatments**” is a planned, structured, and organized program to promote chemical free status which may include different facilities or modalities. Such a program is considered complete when the covered Member (1) is discharged on medical advice from inpatient detoxification, inpatient rehabilitation/Treatment, partial hospitalization or intensive outpatient care or a series of these levels of Treatment without a lapse in Treatment, or (2) fails to materially comply with the Treatment program for a period of thirty (30) days.

1.76 “**Service Area**” is that geographic area more fully described in the Scott and White Health Plan Service Areas and Provider Locations attachment to this Agreement, in which Health Plan may offer this Agreement.

1.77 “**Short-term Therapy**” is that therapeutic service, or those therapeutic services, which when applied to a covered injury or illness under this agreement, meet or exceed Treatment goals in accordance with the Individual Treatment Plan.

1.78 “**Subscriber**” means the eligible employee or other person whose employment or other status, except family dependency, is the basis for eligibility under the terms, conditions, and limitations of this Agreement and for or on behalf of whom the Premiums are paid by the Group.

1.79 “**Toxic Inhalant**” means a volatile chemical under the Texas Controlled Substance Act (Chapter 481 of the Texas Health and Safety Code).

1.80 “**Treatment**” or “**Treatments**” means services, supplies, drugs, equipment, protocols, procedures, therapies, surgeries and similar terms used to describe ways to treat a health problem or condition.

1.81 “**Urgent Care Facility**” means any licensed Facility that provides physician services for the immediate treatment only of an injury or disease, and which has contracted with the Health Plan to provide Members such services.

1.82 “**Urgent Care**” means services provided for the immediate treatment of a medical condition that requires prompt medical attention but where a brief time lapse before receiving services will not endanger life or permanent health. Urgent conditions include, but are not limited to, minor sprains, fractures, pain, heat exhaustion, and breathing difficulties other than those of sudden onset and persistent severity. An individual patient's urgent condition may be

determined emergent upon evaluation by a Participating Provider.

1.83 “**Usual, Customary and Reasonable Charges**” means the fee which a physician or other provider of a particular service usually charges his/her patients for the same service and which is within the range of fees usually charged by other physicians or other providers located within the immediate geographic area where the service is received under similar or comparable circumstances. When applied to a Participating Provider, it means the amount allowed under a Participating Provider’s agreement with the Health Plan.

1.84 “**Waiting Period**” means the period of time specified by Group that must pass before a person becomes eligible for coverage under this Agreement.

1.85 “**You**” means the Subscriber.

1.86 “**Your**” means relating or pertaining to the Subscriber.

2. ELIGIBILITY PROVISIONS

2.1 General Eligibility Provisions

2.1.1 All determinations and interpretations of membership eligibility and effective dates shall be made solely by the Employees Retirement System of Texas (ERS) in accordance with the Rules and Regulations of the Board of Trustees of the Employees Retirement System (Rules). The following is a summary of the most commonly used eligibility rules. In the event of any omissions or conflicts, the Rules prevail.

2.1.2 Employees and retirees of the state of Texas may enroll in an HMO, provided the HMO is approved by the Board of Trustees of the ERS.

2.2 Additional Provisions

2.2.1 It is the responsibility of ERS to inform Health Plan of all changes that affect Member eligibility, including but not limited to marriage of a Covered Dependent, death, address changes, etc.

3. PROVIDERS OTHER THAN HEALTH PLAN PROVIDERS

3.1 Health Plan Not Liable for Expenses of Providers Other Than Health Plan Providers

Health Plan will not be liable for services until the Member, in advance, authorizes Health Plan to assume full responsibility for arranging Member’s care utilizing Participating Primary Care Physicians and other Participating Providers. Services are not covered under this Agreement until such date that the Health Plan assumes full responsibility for the Member’s care except as follows:

- for Emergency Care or services for a Covered Dependent child who lives outside of the Service Area;
- for a Member who is confined in a hospital, which is not a Participating Hospital or under the care of a physician or provider who is not a Participating Provider on the date coverage under this Agreement would otherwise become effective.

Health Plan shall not be required to cover, provide or pay costs of, or otherwise be liable for, services rendered to the extent that such services were rendered prior to the Effective Date of coverage, or if such services would not have been covered under this Agreement.

3.2 Contract Status of Providers

You should be aware of the contract status of the providers from whom you receive treatment, especially participating hospitals, as some facility-based physicians or other health care practitioners such as anesthesiologists, pathologists, and radiologists may not be included in Health Plan’s network and may balance bill for amounts not paid by Health Plan. In order to determine the contract status of providers you may consult the provider manual on the Health Plan website at [www.swhp.org], or contact a Health Plan Customer Service Representative at [800-321-7947].

4. TERMINATION OF COVERAGE

4.1 Termination of Coverage for Members

Coverage under this Agreement shall terminate for You and/or Your Covered Dependents as follows:

- 1) except for continuation privileges, on the date on which You and/or Your Covered Dependents cease to be eligible for coverage in accordance with this Agreement; or
- 2) thirty-one (31) days after written notice from Health Plan that a Participating Provider, after reasonable efforts, including the opportunity to select

another Primary Care Physician, Referral Physician or Health Professional, has been unable to establish a satisfactory patient relationship with You or Your Covered Dependent. Prior to providing written notice of termination, Health Plan shall specify in writing the changes that are necessary in order to avoid termination; or

3) in the event of fraud or intentional misrepresentation by You or Your Covered Dependent, except as described under Incontestability, or fraud in the use of services or facilities, sixteen (16) days after written notice from Health Plan; or

4) on the date You or Your Covered Dependent commits any act detrimental to safe Health Plan operations and the delivery of services; or

5) the date Group coverage terminates.

4.2 **Termination or Non-Renewal of Coverage for Group**

This Agreement shall continue in effect for one (1) year from the Effective Date. After that, this Agreement may be renewed annually. This Agreement may be terminated or non-renewed if Group fails to comply with the terms and conditions of the GBP Contractual Agreement.

4.3 **Liability**

Upon termination of coverage as described above, Health Plan shall have no further liability or responsibility under this Agreement except as may be required under the continuation privileges.

5. CONTINUATION OF COVERAGE OPTION

5.1 **Loss of Eligibility**

Members who lose eligibility under this Agreement may be eligible to continue coverage under this Agreement according to state or federal law. Contact the Group for more information if eligibility for membership ends due to the occurrence of one of the following qualifying events:

- 1) the death of the covered Subscriber;
- 2) the termination (other than for gross misconduct) or reduction of hours of the Subscriber's employment;
- 3) the divorce or legal separation of the Subscriber from the Subscriber's spouse;
- 4) the Subscriber (excluding Covered Dependents who may continue coverage under this Agreement) becomes entitled to benefits under Medicare;
- 5) a dependent child ceases to be a dependent child under the generally applicable requirements of the Group;
- 6) the Contract Holder commences Chapter 11 bankruptcy proceedings; or

7) Group coverage ends for any other reason except involuntary termination for cause and the Member has been covered continuously under the group coverage (including any replacement group coverage) for at least three consecutive months immediately prior to termination.

5.2 **COBRA Continuation of Coverage**

The Group will provide written notice to each Member enrolled through the Group of the continuation coverage available to Members under the Consolidated Omnibus Budget Reconciliation Act (COBRA). If any Member is granted the right to continue coverage beyond the date when Member's coverage would otherwise terminate, this Health Plan will be deemed to allow continuation of coverage to the extent necessary to comply with COBRA requirements. Member should contact the employer or Group Contract Holder for verification of eligibility and to obtain procedures for obtaining benefits.

5.3 **Additional Continuation Provisions**

Upon completion of any continuation of coverage as provided under COBRA, any Member whose coverage under this Agreement has been terminated for any reason except involuntary termination for cause, and who has been continuously covered under this Agreement or any similar group contract providing similar services and benefits which it replaces for at least three (3) consecutive months immediately prior to termination shall be eligible to continue coverage as follows:

- 1) Continuation of group coverage must be requested in writing within 31 days following the later of:
 - a. the date the group coverage will terminate; or
 - b. the date the Member is given notice of the right of continuation by either the employer or the Contract Holder.
- 2) A Member electing continuation coverage must pay to the employer or Contract Holder on a monthly basis, in advance, the Premiums, plus 2% of the total health premium when due.
- 3) Continuation coverage will continue until the earliest of:
 - a. 6 months after the date the election for continuation coverage is made;
 - b. the date on which failure to make payments would terminate coverage;
 - c. the date on which the Member is covered for similar services and benefits by another health plan; or
 - d. the date on which this Agreement terminates as to all Members.
- 4) If the Subscriber dies, retires or the Subscriber's family relationship with Covered Dependents is otherwise terminated due to "divorce," which term shall include annulment and legal separation for purposes of this Section, and a Covered Dependent loses coverage,

the Subscriber's Covered Dependent may continue group coverage pursuant to this Agreement. Continuation coverage will not be conditioned in any way on the Covered Dependent's health status or condition. However, this continuation coverage does not include Covered Dependents who have been covered pursuant to this Agreement for less than one year, except for covered dependent children less than one year of age. The premiums charged for this continuation coverage shall be no more than the premiums charged for all other individuals covered by this Agreement. To elect this continuation coverage, the subscriber, his or her personal representative or the Covered Dependent must notify Group within fifteen (15) days of the Subscriber's death, retirement or divorce. Upon receipt of such notice, the Group will immediately give written notice to each affected Covered Dependent. The Covered Dependent must give written notice to the Group of its desire to continue coverage under this Agreement within sixty (60) days of the Subscriber's death, retirement or divorce. Coverage under this Agreement will remain in effect during the sixty (60) day period, provided that written notice is given, and the required premium paid, within the sixty (60) day period. This continuation coverage shall be concurrent with any other continuation coverage provided for under this Agreement. This continuation coverage will terminate upon the earlier of the following:

- a. the day a premium is due and unpaid; or
- b. the day the Covered Dependent becomes eligible for similar coverage; or
- c. three (3) years from the date of the Subscriber's death, retirement or divorce.

5.4 **Texas High Risk Pool Coverage Notification**

Health Plan will notify Member that Member may be eligible for coverage under the Texas Health Insurance Risk Pool and provide Member with the address and toll-free telephone number to make application to the Texas Health Insurance Risk Pool not less than 30 days before termination of continuation of coverage under this Agreement.

6. REQUIRED PAYMENTS

6.1 **Copayments and Deductibles**

You are responsible for paying any applicable Copayment and/or Deductibles for Health Care Services. Copayments are due at the time the service is rendered. Copayments and Deductibles are required payments from You.

6.2 **Subrogation and Coordination of Benefits Payments**

If You, Your Covered Dependents, or anyone on behalf of You or Your Covered Dependents receives benefits or monies subject to the coordination of benefits or subrogation provisions of this Agreement, You must submit to Health Plan within 31 days of receipt of such benefits or monies, the amount to which Health Plan is entitled. In the event You, Your Covered Dependents, or anyone on behalf of You or Your Covered Dependents should recover amounts due under the subrogation or coordination of benefits provisions, any amount recovered is considered to be a required payment from You to Health Plan.

7. HEALTH CARE SERVICES

7.1 **Health Care Services Within the Service Area**

You and Your Covered Dependents shall be entitled to the Health Care Services specified in the Schedule of Benefits subject to the conditions and limitations stated in the Schedule of Benefits and this Agreement that are considered to be Medically Necessary by the Medical Director. Except for Emergency Care, approved referrals, or covered medical services rendered to a Covered Dependent child under a Qualified Medical Support Order who is outside the Service Area, Health Care Services are available only through Participating Providers as ordered and coordinated by Your, or Your Covered Dependent's, Primary Care Physician. Health Plan shall have no liability or obligation whatsoever for any service or benefit sought or received by You or Your Covered Dependents from any other physician, hospital, extended care facility, or other person, institution or organization, unless prior approval for referral has been obtained from Your, or Your Covered Dependent's Primary Care Physician and Medical Director.

7.2 **Health Care Services Outside of the Service Area**

Other than for Emergency Care, out-of-area referrals approved under the terms of this Agreement or covered medical services for Your Covered Dependent child under a Qualified Medical Support Order, if You or Your Covered Dependent are outside of the Service Area, You or Your Covered Dependent must return to the Service Area and to Participating Providers to receive Health Care Services provided under this Agreement.

7.3 **Limitations and Exclusions**

The Health Care Services and other benefits to be provided under this Agreement are limited by or excluded from coverage as stated in the Description of Benefits.

7.4 **Health Care Services that are not Medically Necessary**

In the event that the Medical Director determines that a Health Care Service proposed or provided, to You or Your Covered Dependent is not medically necessary, You and the Physician or Provider requesting or providing such Health Care Service shall be notified of this determination, and an Adverse Determination will be issued.

An Adverse Determination will include the reason for the Adverse Determination, the clinical basis for the Adverse Determination, a description of the criteria used in making the Adverse Determination, and a description of the complaint and appeals process. You and the Physician or Provider requesting the Health Care Service will be notified as follows:

- Within one hour for post-stabilization care subsequent to emergency treatment;
- Within 24 hours when care is requested while You or Your Covered Dependent is Hospitalized; or
- Within three working days in other circumstances.

The initial notice of Adverse Determination may be by telephone or electronic transmission to Your Provider, and will be followed by written notice to You and Your Provider within two working days.

7.5 **Nature of Coverage Provided and Health Plan's Right to Contract**

7.5.1 **Health Care Services and Your Beliefs**

You understand that the Health Plan is a health maintenance organization and not an indemnity insurance company and that Health Plan arranges for the provision of Health Care Services through contractual arrangements with certain providers. Health Plan reserves the right to contract with such providers of Health Care Services as it shall determine can reasonably provide them. Health Plan's Participating Providers shall determine the manner of provision of those Health Care Services and such services are subject to their discretion. Not every form of Treatment may be provided, and even though certain of Your personal beliefs or preferences may be in conflict with the care as offered by Participating Providers, You shall not be entitled to any specific class of licensed provider, school of approach to such services or otherwise be able to determine the providers who will care for You or Your Covered Dependents other than as provided in this Agreement. This provision does not restrict Your right to consent or agree to any procedure or Treatment. However, this provision defines the coverage provided under this Agreement. Your decision to follow medical advice or to seek any particular Treatment is solely yours and you agree to bear all legal and ethical consequences of the decision without regard to the coverages provided hereunder.

7.5.2 **Provision of Health Services**

Except as specified in the Description of Benefits, if Participating Providers fail to, or become unable to, render the Health Care Services which they have agreed to provide, Health Plan agrees to coordinate through its Medical Director the provision of Health Care Services to Members.

7.6 **Refusal to Accept Treatment**

Should You or Your Covered Dependent refuse to cooperate with or accept the recommendations of Participating Providers with regard to health care for Your or Your Covered Dependent, Participating Providers may regard such refusal as a failure of the patient relationship and as obstructing the delivery of proper medical care. In such cases, Participating Providers shall make reasonable efforts to accommodate You or Your Covered Dependent. However, if the Participating Provider determines that no alternative acceptable to the Participating Provider exists, You shall be so advised. If You or Your Covered Dependent continues to refuse to follow the recommendations, then neither Health Plan nor its Participating Providers shall have any further responsibility under this Agreement to provide care for the condition under Treatment, and may terminate Your or Your Covered Dependent's coverage in accordance with this Agreement.

7.7 **Coordination of Health Care Services**

7.7.1 **Designation of Primary Care Physician**

At the time of enrollment under this Agreement, You or Your Covered Dependents should designate a Primary Care Physician to coordinate the delivery of Health Care Services. Should You or Your Covered Dependent fail to designate a Primary Care Physician, Health Plan will assign one.

7.7.2 **Selection of Primary Care Physician**

Primary Care Physicians must be selected from the list of Primary Care Physicians published by the Health Plan and supplied to each new Member. The right to select a particular Participating Physician as a Primary Care Physician is subject to that physician's availability. A current, updated list of Primary Care Physicians may be found at www.ers.state.tx.us.

7.7.3 **Changing Your Primary Care Physician**

You or Your Covered Dependents may change Your Primary Care Physician designation as reasonable to reflect changes in Your medical needs (for example, a Covered Dependent changing from a pediatrician to an internist) or preferences. A Primary Care Physician may also require You to change to another Primary Care Physician.

7.7.4 **Role of Primary Care Physician**

The Primary Care Physician is responsible for coordinating medical care and the delivery of Health Care Services under this Agreement. Except for Emergency Care Services,

weekend/evening clinics, OB/GYN services, and eye refractions through participating optometrists, You and Your Covered Dependents must contact Your Primary Care Physician for all Health Care Services, including, but not limited to, referral to a Referral Physician or to a physician or facility not under contract with Health Plan.

7.7.5 Access to Specialist without Referral

Effective only after approval by Health Plan, if You or Your Covered Dependent has a chronic, life-threatening, or disabling condition, You may apply to the Medical Director to be allowed to access a physician specialist without having to have a referral from a Primary Care Physician. The following conditions must be met:

- the condition must, in the opinion of the Medical Director, qualify;
- the specialist must agree to provide the necessary specialty care and coordinate the other health care needs of the patient; and
- the specialist must be qualified, in the opinion of the Medical Director, to perform these dual roles.

The Medical Director's decision to deny the request may be appealed as described in the Complaint and Appeal Procedure.

7.7.6 Open Access to OB/GYN

In addition to a Primary Care Physician, a female Member may select an OB/GYN Physician to provide obstetrical and gynecological specialty medical services under the terms of the Health Care Agreement. As used herein, OB/GYN Physician means a Participating Physician approved by the Health Plan to provide obstetrical or gynecological services. The terms of this Agreement and Health Plan's rules pertaining to the Member's selection and deselection of a Primary Care Physician shall apply to the selection and deselection of an OB/GYN Physician. A female Member may have only one OB/GYN Physician at a time. The selected OB/GYN Physician shall have the right to accept, reject or terminate that Member as his or her patient. Once the Member has selected and been accepted by an OB/GYN Physician, the Member may receive Medically Necessary obstetrical and gynecological specialty medical services from that OB/GYN Physician without having to have approval or authorization from the Member's Primary Care Physician or Health Plan. However, the selected OB/GYN Physician may limit the range of obstetrical and gynecological services he or she provides under the terms of this Agreement.

7.8 Continuity of Treatment

7.8.1 Notice of Termination of Treating Physician or Provider

Each contract between the Health Plan and a physician or provider provides that no less than thirty (30) days advance notice be given to You and Your Covered Dependents under

Treatment by a physician or provider of the physician's or provider's impending termination from the Health Plan.

7.8.2 Continued Treatment by Terminated Physician or Provider

Except for medical incompetence or unprofessional behavior, the termination does not release the Health Plan from reimbursing the Participating Provider for providing Treatment to You or Your Covered Dependent in certain special circumstances. Special circumstance means a condition which Your physician or provider, or Your Covered Dependent's physician or provider reasonably believes could cause harm to You or Your Covered Dependent if the physician or provider discontinues Treatment of the Member, and includes a disability, acute condition, life-threatening illness, or being past the twenty-fourth week of pregnancy. However, the Participating Provider must first identify the special circumstance and submit a request to Health Plan's Medical Director that You or Your Covered Dependent be permitted to continue Treatment under the Participating Provider's care. The Participating Provider must agree not to seek payment from You or Your Covered Dependent of any amounts for which You would not be responsible if the Health Professional or Participating Physician were still under contract with the Health Plan. If the request is granted, the Health Plan's obligation to pay for the services of the Participating Provider shall not exceed 90 days from the date of termination or nine (9) months in the case of a terminal illness with which You or an Covered Dependent was diagnosed at the time of the termination and shall not exceed the contract rate. If You or a Covered Dependent is past the twenty-fourth (24th) week of pregnancy at the time of termination, Health Plan's obligation to reimburse a terminated Participating Provider for services extends through delivery of the child, immediate postpartum care and the follow-up checkup within the first six weeks of delivery.

7.9 Health Care Services Not Available From Contracting Providers

To the extent the Health Plan would have covered such services under the terms of this Agreement, Medically Necessary Health Care Services which are prescribed by a Participating Physician but which are not available from a Participating Provider shall be authorized as described under the heading, Out-of-Network Referrals, in the Description of Benefits to this Agreement, within a time appropriate to the circumstances relating to the delivery of services and the condition of the patient, but in no event to exceed five (5) business days after receipt of reasonably requested documentation, to be received from a physician or provider who does not contract with the Health Plan upon the request of the Participating Physician and the approval by the Medical Director. If approved, Health Plan shall fully reimburse the non-contracting physician or provider according to the terms of the Health Care Agreement at the

usual and customary or agreed upon rate, except for Copayments, and charges for non-covered services. . In no event should You be balance billed for Covered Services approved under this provision. If You are balance billed please contact one of our customer service representatives and we will remedy this issue with the Physician or Provider. Prior to issuing a denial, the Medical Director must provide for a review by a specialist of the same or similar specialty as the type of physician or provider to whom a referral is requested.

8. CLAIM PROCEDURE

8.1 Necessity of Filing Claims

You will not ordinarily need to pay any person or facility for Health Care Services provided under this Agreement other than copayments or deductibles as specified in the Summary of Benefits. However, if you receive Health Care Services from facilities which do not routinely contract with Health Plan, for example in the case of an emergency, you may be asked to pay that person or facility directly. You are entitled to reimbursement for such payments to the extent those Health Care Services are covered under this Agreement provided (1) You submit written proof of and claim for payment to Health Plan at its office, (2) the written proof and claim for payment are acceptable to Health Plan, (3) Health Plan receives the written proof and claim for payment within 60 days of the date the Health Care Services were received by You or Your Covered Dependent, and (4) You have complied with the terms of this Agreement.

8.2 Effect of Failure to File Claim Within 60 Days

Failure to submit written proof of and claim for payment within the 60 day period shall not invalidate or reduce Your entitlement to reimbursement provided it was not reasonably possible for You to submit such proof and claim within the time allowed and written proof of and claim for payment were filed as soon as reasonably possible. Written proof and claim for payment submission should consist of itemized receipts containing: name and address where services were received, date service was provided, amount paid for service, and diagnosis for visit. Claims for reimbursement should be sent to Scott & White Health Plan, Attn: Claims Dept., 2401 South 31st St., Temple, TX 76508. In no event will Health Plan have any obligation under this paragraph if such proof of and claim for payment is not received by Health Plan within one (1) year of the date the services were provided to You or Your Covered Dependent.

8.3 Acknowledgement of Claim

Not later than the fifteenth (15th) day after receipt of Your claim, the Health Plan will acknowledge in writing receipt of

the claim; begin any investigation of the claim; and request from You any necessary information, statements or forms. Additional requests for information may be made during the course of the investigation.

8.4 Acceptance or Rejection of Claim

Not later than the fifteenth (15th) business day after receipt of all requested items and information, Health Plan will notify You in writing of the acceptance or rejection of the claim and the reason if rejected; or notify You that additional time is needed to process the claim and state the reason Health Plan needs additional time. If additional time is needed to make a decision, Health Plan shall accept or reject the claim no later than the forty-fifth (45th) day after you have been notified of the need for additional time.

8.5 Payment of Claims

Claims will be paid no later than the fifth (5th) business day after notification of acceptance.

8.6 Payment to Physician or Provider

Payment by Health Plan to the person or facility providing the services to You or Your Covered Dependent shall discharge Health Plan's obligations under this Section.

8.7 Limitations on Actions

No action at law or in equity shall be brought to recover payment of a claim under this Agreement prior to the expiration of sixty (60) days from the date written proof of and claim for payment, as described above, was received by Health Plan. In no event shall such action be brought after one (1) year from such date.

9. EFFECT OF MEDICARE, SUBROGATION AND COORDINATION OF BENEFITS

9.1 Effect of Medicare

9.1.1 For employees who retired and were Medicare eligible before September 1, 1992, HMO will provide benefits secondary to Medicare Part B, if the retiree is enrolled in Medicare Part B. If the retiree is not enrolled in Medicare Part B, HMO will pay primary benefits. The HMO may not require Part B coverage as a condition of enrollment for those retirees.

For employees who retired and became Medicare eligible on or after September 1, 1992, HMO will provide benefits secondary to Medicare Part B as if the retiree were enrolled in Medicare Part B, whether or not the retiree is enrolled in Medicare Part B. The HMO may provide only secondary

benefits for any GBP participant eligible for Medicare coverage as a result of end-stage renal disease if the participant declines to elect Medicare Part B coverage.

9.2 **Subrogation**

9.2.1 **Health Plan's Right to Reimbursement**

If another person or entity is, or may be, responsible to pay for or provide health care services to You or Your Covered Dependent and if Health Plan paid for or provided those health care services, then Health Plan is entitled to subrogation rights against such person or entity. Health Plan is also entitled to recover from You the value of services provided, arranged, or paid for, when You were reimbursed for the cost of care by another party, including Your auto insurance for Uninsured Motorist and Underinsured Motorist coverage. Health Plan is also entitled to recover its costs and expenses related to recovery activities, including, but not limited to, attorney's fees and court costs.

9.2.2 **Action Against Party Liable**

By receiving service from Health Plan, You assign to Health Plan the right to proceed in Your name to secure right of recovery of its costs, expenses, or the value of services rendered. The value of services rendered which Health Plan is entitled to recover shall be limited to the cost of providing such services. Health Plan is entitled to discharge of its subrogation rights on a prorata basis with any other contractual or statutory subrogation holder. Furthermore, Health Plan is entitled to deem the first amounts received by You as recoupment of the value of health care services or damages to which Health Plan is entitled to subrogate up to the value of Health Plan's claim.

9.2.3 **Cooperation with Health Plan**

You shall cooperate fully in the exercise of these rights of subrogation and shall take no action or refuse to take any action which would prejudice the rights of Health Plan. You may not settle, compromise or release a claim against a third party unless (1) the rights of Health Plan are expressly reserved in the settlement, compromise or release and You advise the Health Plan in writing within such period of time as is reasonably necessary to protect Health Plan's rights, (2) Health Plan is paid in full, or (3) Health Plan has given a written waiver of claim after notice. Health Plan reserves the right to select its own representation, including legal representation, in pursuit of its subrogation rights herein, You shall distribute to Health Plan any subrogation without offset for attorney's fees or other costs of representation.

9.3 **Coordination of Benefits**

9.3.1 If this Coordination of Benefits (COB) provision applies, the order of benefit determination rules will be looked at first. Those rules determine whether the benefits of This Plan (defined below) are determined before or after those of another plan. The benefits of This Plan:

- 1) Shall not be reduced when This Plan determines its benefits before another plan; but
- 2) May be reduced when another plan determines its benefits first.

9.3.2 **Definitions Relating to Coordination of Benefits**

The following definitions apply only to the COB provisions of this Agreement.

9.3.2.1 "Plan" is any of these which provides benefits or services for, or because of, medical treatment:

- 1) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
- 2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title IX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended).
- 3) Auto no fault or medical payments coverage.

Each contract or other arrangement for coverage under 1, 2 or 3 is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

9.3.2.2 "This Plan" is the part of the policy that provides benefits for health care expenses.

9.3.2.3 "Primary Plan/Secondary Plan" means the order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan covering You or Your Covered Dependent.

When This Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

When there are more than two plans covering You or Your Covered Dependent, This Plan may be a Primary Plan as to one or more other plans, and may be a Secondary Plan as to a different plan or plans.

9.3.2.4 "Allowable Expense" means a necessary, reasonable and customary item of expense for health care; when the item of expense is covered at least in part by one or more plans covering You.

The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

When benefits are reduced under a Primary Plan because You do not comply with the plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions or Recertification of admissions or services.

9.3.2.5 “Claim Determination Period” means a calendar year. However, it does not include any part of a year during which You have no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

9.3.3 Order of Benefit Determination and Priority Between Plans

When there is a basis for a claim under This Plan and another plan, This Plan is a Secondary Plan which has its benefits determined after those of the other plan, unless:

The other plan has rules coordinating its benefits with those of This Plan; and

Both those rules and This Plan’s rules require that This Plan’s benefits be determined before those of the other plan. The following rules apply in determining priority:

9.3.3.1 Non-Dependent/Dependents

This Plan determines its order of benefits using the first of the following rules which applies:

The benefits of the plan which covers You as an employee or Subscriber are determined before those of the plan which covers You or Your Covered Dependent as a dependent, except that: You or Your Covered Dependent is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

- 1) secondary to the Plan covering You or Your Covered Dependent as a dependent; and
 - 2) primary to the Plan covering You or Your Covered Dependent as other than a dependent;
- then the benefits of the Plan covering You or Your Covered Dependent as a dependent are determined before those of the Plan covering You or Your Covered Dependent as other than a dependent.

9.3.3.2 Dependent Child of Parents Not Separated or Divorced

Except as stated in paragraph 9.3.3.3 below, when This Plan and another Plan cover the same child as a dependent of different parents:

- 1) the benefits of the Plan of the parent whose birthday falls earlier in a year are determined before

those of the Plan of the parent whose birthday falls later in that year; but

- 2) if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other plan does not have the rule described in paragraph 9.3.3.2(1), but instead has a rule based on gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

9.3.3.3 Dependent Child of Separated or Divorced Parents

If two or more Plans cover a Member who is a dependent child of divorced or separated parents, benefits for the child are determined in this order:

- 1) first, the Plan of the parent with custody of the child;
- 2) then, the Plan of the spouse of the parent with custody of the child; and
- 3) finally, the Plan of the parent not having custody of the child.

However, if a Qualified Medical Support Order states that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph does not apply when any benefits are actually paid or provided before the entity has that actual knowledge.

9.3.3.4 Joint Custody

If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, benefits for the child are determined in accordance with paragraph 9.3.3.2.

9.3.3.5 Active/Inactive Employee

The benefits of a Plan which covers You as an employee who is neither laid off nor retired, or as that employee’s dependent, are determined before those of a plan which covers that person as a laid off or retired employee or as that employee’s dependent. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this paragraph 9.3.3.5 is ignored.

9.3.3.6 Continuation of Coverage

If You or Your Covered Dependent’s coverage is provided under a right of continuation pursuant to federal or state law and You and Your Covered Dependent are also covered under another plan, benefits for You or Your Covered Dependent are determined in this order:

- 1) first, the benefits of the plan covering You as an employee, or as that person's dependent;
- 2) second, the benefits under the continuation coverage.

If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

9.3.3.7 Longer/Shorter Length of Coverage

If none of the above rules determine the order of benefits, the benefits of the Plan which covered You or Your Covered Dependent longer are determined before those of the Plan which covered You or Your Covered Dependent for the shorter time.

9.3.4 Effect on the Benefits of This Plan

This section applies when This Plan is the Secondary Plan in accordance with the order of benefits determination outlined above. In this event, the benefits of This Plan may be reduced under this section. In addition, the benefits of This Plan will be refused when the sum of:

9.3.4.1 The benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and the benefits that would be payable for the Allowable Expense under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made; exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses.

9.3.4.2 When these rules reduce This Plan's benefits, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

9.4 Facility of Payment

Whenever payments which should have been made under This Plan in accordance with this provision have been made under any other plans, This Plan will have the right, exercisable alone and in as sole discretion, to pay directly to any organizations making such other payments any amounts it will determine to be warranted in order to satisfy the intent of this provision. Amounts so paid will be deemed to be benefits paid under This Plan. To the extent of such payments, This Plan will be fully discharged from liability under This Plan.

9.4.1 Right of Recovery

Whenever payments have been made by This Plan with respect to Health Care Services in a total amount in excess of the maximum amount of payment necessary to satisfy the intent of this provision, this Plan will have the right to recover such excess payments from any party to whom or on behalf of whom such payments were made, including:

- 1) the persons to or for whom it has provided such benefits (but only to the extent that person has received payment from another Plan for a service or supply provided under This Plan);
- 2) insurance companies;
- 3) other organizations.

The "amount of the payments made" includes the reasonable cash value of the benefits provided in the form of services.

9.5 Right to Release and Receive Needed Confidential Information

Health Plan will maintain Your and Your Covered Dependents', private health information in a confidential manner, as required by law. Health Plan may use and disclose Your, and Your Covered Dependents', private health information as necessary for treatment, payment and healthcare operations, including coordination of benefits, utilization review, quality assurance, processing of any claim, financial audit, or for any other purpose reasonably related to the provision of benefits under this Agreement, subject to any limitations stated on the Enrollment Application and Health Plan's notice of privacy practices. Except as described above, use and disclosure of Your and Your Covered Dependents' private health information for other purposes will occur only with appropriate written authorization.

Health Plan may release to or obtain from any insurance company or other organization or person any information, with respect to any person, which This Plan deems to be necessary, if permitted by law, as may be necessary to implement this provision.

10. RECORDS

10.1 Records Maintained by Health Plan

Health Plan is entitled to maintain records on You or Your Covered Dependents necessary to administer this Agreement. The Contract Holder or You or Your Covered Dependents shall provide the information required by the Health Plan within a reasonable period of time. The records of the Contract Holder or You or Your Covered Dependents which have a bearing on this Agreement shall be made available to Health Plan for inspection at any reasonable time.

10.2 Necessity of Requested Information

To the extent it is dependent upon the information for an appropriate determination, Health Plan shall not be required to discharge an obligation under this Agreement until requested information has been received by Health Plan in acceptable form. Incorrect information furnished to Health

Plan may be corrected without Health Plan invoking any remedies available to it under this Agreement or at law provided Health Plan shall not have relied upon such information to its detriment.

10.2.1 **Authorization for Health Care Information from Physicians and Providers**

Health Plan is entitled to receive from any physician or provider of health care to You or Your Covered Dependents information reasonably necessary in connection with the administration of this Agreement but subject to all applicable confidentiality requirements. By acceptance of Health Care Services under this Agreement, You or Your Covered Dependents authorize every physician or provider rendering health care hereunder to disclose, as permitted by law upon request, all facts pertaining to You or Your Covered Dependent's care, Treatment and physical condition to Health Plan or to any other physician or provider who is a Participating Provider or Referral Physician rendering services to You or Your Covered Dependents, and to render reports pertaining to the same to, and permit copying of such records and reports by, Health Plan or other such physicians and providers.

10.3 **Notification of Changes in Status**

You shall notify Health Plan immediately in writing of any fact which may affect benefits under this Agreement, including but not limited to:

- eligibility for Medicare;
- coverage under another plan which may be subject to coordination of benefits; and
- eligibility for recovery from a third party of benefits which may be subject to subrogation.

11. COMPLAINT AND APPEAL PROCEDURE

11.1 **Purpose**

11.1.1 Health Plan recognizes that a member, physician, provider, or other person designated to act on behalf of a member may encounter an event in which performance under this Agreement does not meet expectations. It is important that such an event be brought to the attention of the Health Plan. The Health Plan is dedicated to addressing problems quickly, managing the delivery of Health Care Services effectively, and preventing future complaints or appeals.

11.1.2 The Medical Director has overall responsibility for the coordination of the complaint and appeal procedure. For assistance with this procedure, individuals should contact the Health Plan office.

11.2 **Complaints**

11.2.1 Health Plan will send an acknowledgment letter of the receipt of oral or written Complaints from Complainants no later than five (5) business days after the date of the receipt of the Complaint. The acknowledgment letter will include a description of Health Plan's Complaint procedures and time frames. If the Complaint is received orally, Health Plan will also enclose a one-page Complaint form, which must be returned for prompt resolution of the Complaint.

11.2.2 Health Plan will acknowledge, investigate, and resolve all Complaints within thirty (30) calendar days after the date of receipt of the written Complaint or one-page complaint form from the Complainant. However, investigation and resolution of Complaints concerning emergencies or denials of continued stays for hospitalization shall be concluded in accordance with the immediacy of the case and will not exceed one (1) business day from receipt of the Complaint.

11.2.3 Health Plan will investigate the Complaint and issue a response letter to the Complainant within thirty (30) days from receipt of the Complaint explaining the specific medical and/or contractual reasons for the resolution and the specialization of any physician or other provider consulted. The response letter will contain a full description of the process for appeal, including the time frames for the appeals process and the time frames for the final decision on the appeal.

11.3 **Appeals**

11.3.1 If the Complainant is not satisfied with Health Plan's resolution of the Complaint, the Complainant will be given the opportunity to appear before an appeal panel or address a written Appeal to an appeal panel.

11.3.2 Health Plan will send an acknowledgment letter of the receipt of oral or written appeal from Complainants no later than five (5) business days after the date of the receipt of the Appeal. The acknowledgment letter will include a description of Health Plan's Appeal procedures and time frames. If the Appeal is received orally, Health Plan will also enclose a one-page Appeal form, which must be returned for prompt resolution of the Appeal.

11.3.3 Health Plan will appoint members to the complaint appeal panel, which shall advise the Health Plan on the resolution of the Complaint. The complaint appeal panel shall be composed of equal numbers of Health Plan staff, Participating Providers, and members. No member of the complaint appeal panel may have been previously involved in the disputed decision. The Participating Providers must have experience in the same or similar specialty that typically treats the medical condition, performs the procedure or provides the treatment in the area of care that is

in dispute and must be independent of any physician or provider who made any prior determination. If specialty care is in dispute, the appeal panel must include a person who is a specialist in the field of care to which the appeal relates. The members may not be employees of Health Plan.

11.3.4 No later than five (5) business days before the scheduled meeting of the panel, unless the Complainant agrees otherwise, the Health Plan will provide to the Complainant or the Complainant's designated representative:

- 1) any documentation to be presented to the panel by Health Plan staff;
- 2) the specialization of any physicians or providers consulted during the investigation; and
- 3) the name and affiliation of each Health Plan representative on the panel.

11.3.5 The Complainant, or designated representative if the enrollee is a minor or disabled, is entitled to:

- 1) appear before the complaint appeal panel in person or by other appropriate means;
- 2) present alternative expert testimony; and
- 3) request the presence of and question any person responsible for making the prior determination that resulted in the Appeal.

11.3.6 Notice of the final decision of Health Plan on the Appeal will include a statement of the specific medical determination, clinical basis, and contractual criteria used to reach the final decision. The notice will also include the toll-free telephone number and the address of the Texas Department of Insurance.

11.3.7 Health Plan will complete the Appeals Process no later than the thirty (30) calendar days after the date of the receipt of the written request for Appeal or one-page appeal form from the Complainant.

11.3.8 Investigation and resolution of Appeals relating to ongoing emergencies or denials of continued stays for hospitalization shall be concluded in accordance with the medical or dental immediacy of the case but in no event to exceed one (1) business day after the Complainant's request for Appeal. Due to the ongoing emergency or continued hospital stay, and at the request of the Complainant, Health Plan shall provide, in lieu of a complaint appeal panel, a review by a Participating Provider who has not previously reviewed the case and is of the same or similar specialty who typically treats the medical condition, performs the procedure, or provides the treatment under discussion for review of the Appeal. The physician or provider reviewing the Appeal may interview the patient or the patient's designated representative and shall render a decision on the Appeal. Initial notice of the decision may be delivered orally if followed by written notice of the determination within three (3) days. Investigation and resolution of

Appeals after emergency care has been provided shall be conducted in accordance with the standard Appeal process described above, including the right to a review by an appeal panel.

11.4 **Appeal of Adverse Determinations**

11.4.1 A member, a person acting on behalf of the member, or the member's physician or health care provider may appeal an Adverse Determination orally or in writing to a Member Relations Coordinator. Health Plan will send an acknowledgment letter of the receipt of oral or written Appeal of Adverse Determination from Complainants no later than five (5) business days after the date of the receipt of the Appeal. The acknowledgment letter will include a description of the Health Plan's Appeal procedures and time frames, as well as a reasonable list of documents needed to be submitted by the Complainant for the Appeal. If the Appeal is received orally, the Health Plan will also enclose a one-page Appeal form, which must be returned for prompt resolution of the Appeal.

11.4.2 Health Plan will issue a response letter to the patient or a person acting on behalf of the patient, and the patient's physician or health care provider, explaining the resolution of the appeal; and provide written notification to the appealing party of the determination of the Appeal, as soon as practical, but in no case later than thirty (30) calendar days after the date the Health Plan receives the written Appeal or one-page Appeal form from the Complainant. If the Appeal is denied, the written notification shall include a clear and concise statement of:

- 1) the specific clinical basis for the Appeal denial;
- 2) the specialty of the physician or other health care provider making the denial; and
- 3) notice of the appealing party's right to seek review of the denial by an Independent Review Organization as provided in this Evidence of Coverage.

11.4.3 If the "Appeal of Adverse Determinations" is denied and within ten (10) business days the provider sets forth in writing good cause for having a particular type of specialty provider review the case, the Appeal denial shall be reviewed by a Participating Provider in the same or similar specialty who typically treats the medical condition, performs the procedure, or provides the treatment under discussion for review in the Adverse Determination, and such specialty review will be completed within fifteen (15) business days of receipt of the request from the provider.

11.4.4 Health Plan will provide an expedited Appeal procedure for emergency care denials, denials of care for Life-Threatening Conditions and denials of continued stays for hospitalized patients. The procedure will include a review by a Participating Provider who has not previously reviewed the case and who is of the same or a similar specialty who typically treats the medical condition,

performs the procedure, or provides the treatment under discussion for review. The time in which such expedited Appeal will be completed will be based on the medical immediacy of the condition, procedure or treatment, but may in no event exceed one (1) business day from the date all information necessary to complete the Appeal is received.

11.4.5 Notwithstanding any provisions to the contrary, in a circumstance involving an enrollee's life-threatening condition, the enrollee is entitled to an immediate Appeal to an Independent Review Organization and is not required to comply with procedures for an "Appeal of Adverse Determination" described in this Evidence of Coverage.

11.4.6 Health Plan reserves the right to refer any "Appeal of Adverse Determinations" directly to an Independent Review Organization prior to any determination being made through the internal review process described in this Evidence of Coverage.

11.5 **Independent Review of Adverse Determinations**

11.5.1 Health Plan will permit any party whose Appeal of an Adverse Determination is denied to seek review of that determination by an Independent Review Organization assigned to the appeal in accordance with Section 4202.001 et seq. of the Texas Insurance Code.

11.5.2 Health Plan will provide to the Independent Review Organization no later than the three (3) business days after the date of request by the Party a copy of:

- 1) any medical records of the enrollee that are relevant to the review;
- 2) any documents used by the plan in making the determination;
- 3) the written notification described in Section 11.4.2 of this document;
- 4) any documentation and written information submitted to the Health Plan in support of the Appeal; and
- 5) a list of each physician or health care provider who has provided care to the enrollee and who may have medical records relevant to the Appeal.

11.5.3 Health Plan will comply with the Independent Review Organization's determination with respect to the medical necessity or appropriateness of health care items and services for an enrollee.

12. MISCELLANEOUS PROVISIONS

12.1 Confidentiality

In accordance with applicable law, any data or information pertaining to the diagnosis, Treatment, or health of You or Your Covered Dependent or to an application obtained from You or Your Covered Dependent or from any physician or provider by Health Plan shall be held in confidence and shall not be disclosed to any person except: (1) to the extent that it may be necessary to carry out purposes required by or to administer this Agreement with regard to the provision of Health Care Services, payment of Health Care Services, and Health Plan operations; or (2) upon You or Your Covered Dependent's express authorization; or (3) pursuant to a law or in the event of claim or court order for the production of evidence or to discovery thereof; or (4) in the event of claim or litigation between You or Your Covered Dependent and Health Plan wherein such data or information is pertinent, or (5) bona fide medical research or studies by Health Plan. Health Plan shall be entitled to claim the same privilege against such disclosures as the physician or provider who furnishes such information to it is entitled to claim.

12.2 Independent Agents

12.2.1 Health Plan's Participating Providers are independent contractors. Health Plan is not an agent of any Participating Provider, nor is any Participating Provider an agent of the Health Plan.

12.2.2 Participating Providers shall make reasonable efforts to maintain an appropriate patient relationship with Members to whom they are providing care. Likewise, You and Your Covered Dependents shall make reasonable efforts to maintain an appropriate patient relationship with the Participating Providers who are providing such care.

12.2.3 No Contract Holder or Member, in such capacity, is an agent or representative of Health Plan or its Participating Providers. No Contract Holder or Member shall be liable for any acts or omissions of any Participating Provider or its agents or employees.

12.2.4 The determination of whether any Treatment is a covered benefit under this Agreement shall be made by Health Plan according to the terms and conditions of this Agreement. The fact that Treatment has been prescribed or authorized by a Participating Provider does not necessarily mean that it is covered under this Agreement.

12.3 Entire Agreement

This Agreement, attachments, Group's application, and Your completed and accepted Enrollment Application(s) constitute the entire contract between the parties, and all oral representations and warranties have been incorporated into

this Agreement. No agent or other person, except the Executive Director of Health Plan, has the authority to waive any conditions or restrictions of this Agreement, to extend the time for making a payment, or to bind Health Plan by making any promise or representation, or by giving or receiving any information. No changes to this Agreement shall be valid unless in writing and signed by the Executive Director of Health Plan. However, Health Plan may adopt policies, procedures and rules to promote the orderly and efficient administration of this Agreement.

12.4 Severability

In the event of the unenforceability or invalidity of any section or provision of this Agreement, such section or provision shall be enforceable in part to the fullest extent permitted by law, and such invalidity or unenforceability shall not otherwise affect any other section of this Agreement, and this Agreement shall otherwise remain in full force and effect.

12.5 Modification of Terms

During the term of this Agreement and without Your consent or concurrence, this Agreement shall be subject to amendment, modification or termination in accordance with any provision hereof; by mutual agreement between Health Plan and Contract Holder; or as required by law. By electing coverage pursuant to this Agreement or by accepting benefits hereunder, You and Contract Holders agree to all terms, conditions and provisions hereof.

12.6 Not a Waiver

The failure of Health Plan to enforce any provision of this Agreement shall not be deemed or construed to be a waiver of the enforceability of such provision. Similarly, the failure to enforce any remedy arising from a default under the terms of this Agreement shall not be deemed or construed to be a waiver of such default.

12.7 Recovery

If any action at law or in equity is brought to enforce or interpret the provisions of this Agreement, the prevailing party shall be entitled to recover its costs and expenses associated with such action (including, but not limited to, reasonable attorney's fees), in addition to any other relief to which the party may be entitled. Health Plan is also entitled to recover from Contract Holder, Subscriber or Member any overpayment or other inappropriate payment, including, but not limited to, a payment for non-Covered Services or services rendered to a person who was ineligible for group coverage at the time services were provided (collectively, "Excess Payments"). Failure by the Contract Holder, Subscriber or Member to remit any Excess Payments to

Scott and White Health Plan may result in legal action by Scott and White Health Plan.

12.8 Notice

With the exception of electronic notices sent pursuant to subparagraph 7.4 of this Agreement, any notice under this Agreement shall be given by United States Mail, postage prepaid, addressed as follows:

If to Health Plan:
Scott and White Health Plan
2401 South 31st Street
Temple, Texas 76508

If to You:
To the latest address provided by You

If to the Contract Holder:
To the latest address provided by the Contract Holder.

12.9 Incontestability

All statements made by You on the Enrollment Application shall be considered representations and not warranties. The statements are considered to be truthful and are made to the best of Your knowledge and belief. A statement may not be used in a contest to void, cancel or non-renew an enrollee's coverage or reduce benefits unless:

- 1) it is in a written enrollment application signed by You, and
- 2) a signed copy of the enrollment application is or has been furnished to You.

This Agreement may only be contested because of fraud or intentional misrepresentation of material fact on the Enrollment Application. If Health Plan determines that You made a material misrepresentation of health status on the application, Health Plan will notify Group to determine enrollment status.

12.10 Proof of Coverage

Health Plan will provide You with proof of coverage under this Agreement. Such evidence shall consist of an original copy of this Agreement and an identification card as described below. You will also be provided with a current roster of Participating Providers as well as additional educational material regarding the Health Plan and the services provided under this Agreement.

12.11 Identification Card

Health Plan shall issue an identification card which will provide information regarding the type of coverage held and such other information as required by law or relevant regulations. Such cards are the property of the Health Plan and are for identification purposes only. Possession of a

Health Plan identification card confers no right to services or other benefits under this Agreement. To be entitled to such services or benefits the holder of the card must, in fact, be a Member on whose behalf all required payments under this Agreement have actually been paid. Any person receiving services or other benefits to which the person is not then entitled pursuant to the provisions of this Agreement shall be subject to charges at the providers' then prevailing rates. If You permit the use of a Health Plan identification card by any other person, such card may be retained by Health Plan, and all rights of You and Your Covered Dependents, covered pursuant to this Agreement, shall be terminated sixteen (16) days after written notice.

DESCRIPTION OF BENEFITS

13. WHAT'S COVERED?

To understand the benefits available under this Plan, You and Your Covered Dependents should first review this Description of Benefits and the Schedule of Benefits.

The Description of Benefits will help identify what types of services are covered, when and how each benefit will be covered, and how You and Your Covered Dependents can receive Health Care Services. The Section entitled Exclusions and Limitations describes the types of illness, sickness and services that are not covered by this Agreement.

You and Your Covered Dependent's entitlement to Health Care Services is contingent upon such services being determined as Medically Necessary and prescribed or ordered by a designated Primary Care Physician, Participating OB/GYN Physician or, upon an approved referral, a Participating Physician, Participating Provider or Referral Physician. Health Care Services are also contingent upon all definitions, terms, conditions, and limitations on Health Care Services set forth in all parts of this Agreement being met. In order to receive these Health Care Services, You must pay the Copayments and Deductibles specified in the Schedule of Benefits and any amendments and riders to this Agreement. Except for Emergency Care Services, Referrals and Health Care Services provided to a Covered Dependent child under a Qualified Medical Support Order who is outside the Service Area, all of the benefits are to be provided by Participating Physicians and Participating Providers. You must select a Primary Care Physician for You and Your Covered Dependents who will coordinate the delivery of Health Care Services. Demonstrable proof of organic disease is not required for payment of benefits for Alzheimer's disease.

13.1 COPAYMENTS AND DEDUCTIBLES

The Schedule of Benefits identifies Your Copayments, Deductible (individual or family), if any, and other expenses You are responsible to pay. Some benefits have copayments that are applied differently than a typical copayment. If special copayment rules apply, those rules will be explained in that specific benefit section.

13.2 BENEFITS

13.2.1 MEDICAL SERVICES

You and Your Covered Dependents are entitled to the Medically Necessary professional services of Participating Physicians and Participating Providers on an inpatient and outpatient basis. Medical Necessity is determined by the designated Primary Care Physician or Participating OB/GYN Physician, subject to the review of the Health Plan Medical Director.

You and Your Covered Dependents may access preventative Health Care Services and health education programs as determined by Health Plan. We operate within the requirements of TIC 1354.001 regarding coverage for fibrocystic breast conditions.

Examples of covered medical services may include, but are not limited to, the following:

- preventive care,
- physical exams for medical purposes,
- periodic health evaluations for adults,
- well child care,
- routine pediatric and adult immunizations and boosters,
- annual eye and ear examinations,
- newborn hearing screenings,
- office visits,
- consultations by specialists,
- diagnostic procedures including lab and x-ray,
- Treatment for diseases of the eye,
- surgery,
- dialysis,
- chemotherapy and radiation therapy for cancer,
- allergy tests,
- injections,
- home health care.

13.2.2 HOSPITAL SERVICES

You and Your Covered Dependents are entitled to the Medically Necessary services of any Participating Hospital to which You or Your Covered Dependent may be admitted by a Primary Care Physician or Referral Physician. In the event You or a Covered Dependent are admitted to a non-Participating Hospital by a Referral Physician to whom You or Your Covered Dependent were referred in accordance with Health Plan procedures, the services of the non-Participating Hospital will be covered on the same basis as admission to a Health Plan Hospital, provided admission to the non-Participating

Hospital was approved in accordance with this Agreement. Health Plan will cover the cost of a semi-private room, or the equivalent thereof, for covered hospital admissions for routine acute care. For more intense levels of care, that level of care which is Medically Necessary will be covered. Medically necessary services for an inpatient stay following a mastectomy shall be covered under this provision.

Examples of covered hospital services may include, but are not limited to, the following:

- semi-private room,
- inpatient meals and special diets,
- inpatient medications and biologicals,
- intensive care units,
- nursing care, including special duty nursing,
- short term rehabilitation therapy services in the acute hospital setting
- inpatient lab and x-ray,
- skilled nursing facility care,
- inpatient medical supplies and dressings,
- anesthesia,
- inpatient oxygen,
- operating room and recovery room,
- physical therapy,
- radiation therapy,
- inhalation therapy,
- administration of whole blood and blood plasma.

13.2.3 EMERGENCY CARE SERVICES

13.2.3.1 QUALIFICATION OF EMERGENCY SERVICES

Medically Necessary Emergency Care is covered by this Agreement, including the treatment and stabilization of an emergency medical condition. However, only those conditions meeting the terms of the definition of Emergency Care will qualify. Health Plan will provide for any medical screening examination or other evaluation required by Texas or federal law that takes place in a hospital emergency facility or comparable facility, and that is necessary to determine whether an emergency medical condition exists. Medically Necessary Emergency Care received from a non-participating Physician or non-Participating Provider will be fully reimbursed according to the terms of the Health Care Agreement at the usual and customary or agreed upon rate, except for Copayments, and charges for non-covered services. In no event should You be balance billed for Medically Necessary Emergency Care received from a non-participating Physician or non-Participating Provider. If You are balance billed please contact one of our customer service representatives and we will remedy this issue with the Physician or Provider.

13.2.3.2 URGENT CARE SERVICES

Urgent Care services provide for the immediate treatment of a medical condition that requires prompt medical attention but where a brief time lapse before receiving services will not endanger life or permanent health. Member shall be required to pay the Copayment stated in the Schedule of Benefits for Treatment administered at an Urgent Care Facility. Unless designated and recognized by Health Plan as an Urgent Care Facility, neither a hospital nor an emergency room will be considered an Urgent Care Facility.

13.2.3.3 EMERGENCY TRANSPORTATION SERVICES

Emergency transportation, when and to the extent it is Medically Necessary, is covered when transportation in any other vehicle would endanger the patient's health. Health Plan will not cover air transportation if ground transportation is medically appropriate and more economical. If these conditions are met, Health Plan will cover ambulance transportation to the closest appropriate hospital or skilled nursing facility.

13.2.3.4 EMERGENCY MEDICAL SERVICES

Emergency medical services provided by ambulance personnel for which transport is unnecessary or is declined by Member will not be covered.

13.2.3.5 TRANSPORTATION TO PARTICIPATING FACILITY AFTER STABILIZATION

Once You or Your Covered Dependent's condition is stabilized and as medically appropriate, Health Plan may require transfer to a Participating Hospital to appropriately manage patient's care. Where stabilization of an emergency medical condition originates in a hospital emergency facility or comparable facility, Treatment following such stabilization may require approval by Health Plan. The treating physician or provider must make the request for post-stabilization care. Health Plan will approve or deny such request within the time appropriate to the circumstances relating to the delivery of services and the condition of the patient, but in no event to exceed one hour from the time of the request.

13.2.3.6 EMERGENCY CARE COVERAGE EXCEPTIONS/LIMITATIONS

Health Plan will not cover any expenses involving non-emergent/non-urgent Treatments performed or prescribed by non-Participating Physicians or non-Participating Providers, either inside or outside of the Service Area, and for which Health Plan has not authorized a referral. Complications of those Treatments will not be covered prior to the date Health Plan arranges for patient's transfer

to a Participating Physician or Participating Provider. In no event shall Health Plan cover any Treatments which are excluded from coverage under this Agreement or complications of those Treatments.

13.2.3.7 HOSPITALIZATION AT OTHER THAN PARTICIPATING HOSPITAL

If You or Your Covered Dependent is hospitalized at other than a Participating Hospital, You must notify Health Plan within forty-eight (48) hours of admission or as soon thereafter as it is reasonably possible, and Health Plan shall provide information about its obligations under this Agreement. Failure to provide notification may result in denial of payment unless it is shown not to have been reasonably possible to give such notice.

13.2.4 MENTAL HEALTH CARE

Medically Necessary Inpatient and Outpatient Treatment of Your or Your Covered Dependent's mental illness, emotional disorders and Serious Mental Illness are determined by the designated Primary Care Physician. Services provided for Outpatient Mental Health Care and Inpatient Mental Health Care listed below are limited to those services which, in the judgment of a Participating Physician, meet or exceed Treatment goals as set forth in the Individual Treatment Plan within the benefits described below. Copayment levels and limits for Outpatient and Inpatient Mental Health are not covered under Serious Mental Illness Coverage. Covered services include the following:

13.2.4.1 OUTPATIENT MENTAL HEALTH CARE

For the Treatment of mental illness other than Serious Mental Illness, You or Your Covered Dependents are entitled to outpatient diagnostic and therapeutic services provided by Participating Psychiatrists and other Health Professionals.

13.2.4.2 INPATIENT MENTAL HEALTH CARE

For the Treatment of mental illness other than Serious Mental Illness, You or Your Covered Dependents are entitled to inpatient diagnostic and therapeutic services provided by Participating Mental Health Providers.

13.2.4.3 COPAYMENTS AND DAY LIMITS ON MENTAL HEALTH CARE

For outpatient mental health care other than Serious Mental Illness, You or Your Covered Dependents are entitled to the number of outpatient mental health care visits per Contract Year stated in the Schedule of Benefits. You are required to pay the Copayment for each outpatient mental health care visit to or by a Health

Professional during normal working hours on a Participating Provider's premises and on weekends, after normal working hours, or away from Participating Provider's premises as stated in the Schedule of Benefits.

For inpatient mental health care other than Serious Mental Illness, You or Your Covered Dependents are entitled to the number of days for inpatient services per Contract year stated in the Schedule of Benefits. You are required to pay the Copayment for each day of inpatient mental health care with a Participating Provider as stated in the Schedule of Benefits.

13.2.4.4 PSYCHIATRIC DAY TREATMENT FACILITY

Psychiatric Day Treatment Facility services are available for Medically Necessary mental health evaluations, diagnostic and therapeutic services, as shall be recommended by a Participating Physician in lieu of hospitalization upon a referral to such facility, if any, with which Health Plan may maintain an agreement for the provision of such services. In order to be considered for coverage, the Participating Physician attending a member must certify that treatment at such facility is in lieu of hospitalization. Two (2) days of Treatment at a Psychiatric Day Treatment Facility shall be counted as one (1) day of inpatient care for purposes of applying the stay in such a facility against the inpatient mental health care limits stated in the Schedule of Benefits.

13.2.4.5 RESIDENTIAL AND STABILIZATION MENTAL HEALTH TREATMENT

Alternative mental health Treatment benefits are available for Medically Necessary Treatment of mental and emotional disorders, including mental health evaluations, diagnostic and therapeutic services in a Residential Treatment Center for Children and Adolescents or a Crisis Stabilization Unit as shall be prescribed by a Participating Physician in lieu of hospitalization upon a referral to such facility, if any, with which Health Plan may maintain an agreement for the provision of such services in Health Plan's Service Area.

13.2.4.6 QUALIFICATION OF RESIDENTIAL AND STABILIZATION MENTAL HEALTH TREATMENT

The above alternative mental health Treatment benefits may be covered by Health Plan under the following conditions:

- 1) as determined by a Participating Physician specializing in psychiatry, You or Your Covered Dependents have a serious mental illness which substantially impairs thought, perception of reality, emotional process, or judgment or grossly impairs behavior as manifested by recent disturbed behavior and which would otherwise necessitate confinement in a hospital if such care and Treatment were not

available through a Crisis Stabilization Unit or Residential Treatment Center for Children and Adolescents;

2) the services rendered for which benefits are to be paid must be based on an Individual Treatment Plan; and

3) providers of services for which benefits are to be paid must be licensed or operated by the appropriate state agency or board to provide those services, be located within the Service Area, and be designated by Health Plan as an approved provider with which Health Plan has entered into an agreement for the provision of such services.

Two (2) days of Treatment at a Residential Treatment Center for Children and Adolescents or Crisis Stabilization Unit shall be counted as one (1) day of inpatient care for purposes of applying the stay in such a facility against the inpatient mental health care limits stated in the Schedule of Benefits.

13.2.4.7 SERIOUS MENTAL ILLNESS

Treatment for Serious Mental Illness, which includes Medically Necessary Medical Services and Hospital Services, shall be provided under this Agreement as indicated in the Schedule of Benefits. Treatment for Serious Mental Illness is not covered under Outpatient Mental Health Care or Inpatient Mental Health Care coverage provided in sections 13.2.4.1 and 13.2.4.2 of this Agreement.

“Serious Mental Illness” means the following psychiatric illnesses: schizophrenia, paranoid and other psychotic disorders; bipolar disorders (hypomanic, manic, depressive, and mixed), major depressive disorders (single episode or recurrent), schizo-affective disorders (bipolar or depressive), obsessive-compulsive disorders, and depression in childhood and adolescence.

13.2.4.8 COPAYMENTS AND DAY LIMITS ON TREATMENT FOR SERIOUS MENTAL ILLNESS

You will pay the same Copayments for the Treatment of Serious Mental Illness as for any other physical illness. Treatment for Serious Mental Illness is unlimited as stated in the Schedule of Benefits. The number of days for which You or Your Covered Dependent would pay for an inpatient Hospital stay is the same as you would pay for an inpatient Serious Mental Illness stay.

13.2.5 TREATMENT FOR CHEMICAL DEPENDENCY

13.2.5.1 TREATMENT FOR CHEMICAL DEPENDENCY

You or Your Covered Dependents are entitled to Medically Necessary care and Treatment for Chemical Dependency on the same basis as physical illness generally, subject to the applicable limitations and exclusions, provisions of this Agreement, and the Standards for Reasonable Cost Control and Utilization Review for Chemical Dependency Treatment Centers, adopted by the Texas Department of Insurance.

13.2.5.2 COPAYMENT FOR CHEMICAL DEPENDENCY

You or Your Covered Dependents are required to pay the same Copayments for Outpatient Treatment for Chemical Dependency as for other outpatient benefits provided under this Agreement. You or Your Covered Dependents are required to pay the same Copayments for Inpatient Treatment for Chemical Dependency as for other inpatient benefits provided under this Agreement.

13.2.6 REHABILITATIVE THERAPY

13.2.6.1 REHABILITATIVE THERAPY

As recommended by a Participating Physician or Referral Physician as Medically Necessary, outpatient rehabilitative therapy services are available for services for physical, inhalation, speech, hearing, and occupational therapies. Rehabilitation and services that, in the opinion of the Participating Physician or Referral Physician are Medically Necessary, shall not be denied, limited or terminated as long as they meet or exceed Treatment goals for You or Your Covered Dependent in accordance with an Individual Treatment Plan. For a physical disability, treatment goals may include maintenance of functioning, prevention of deterioration, or slowing of further deterioration.

13.2.6.2 EARLY CHILDHOOD INTERVENTION SERVICES

Medically Necessary Covered Rehabilitative Therapy Services provided to a Covered Dependent under the age of 18 in accordance with an individualized family service plan issued by the Interagency Council on Early Childhood Intervention will be reimbursed.

13.2.6.3 COPAYMENT FOR REHABILITATIVE THERAPY

You are required to pay a Copayment for each outpatient therapy visit to or by a Health Professional during normal working hours on the provider's premises, on weekends, after normal working hours or away from the provider's premises as indicated in the Schedule of Benefits.

13.2.7 HOME HEALTH SERVICES

Home health services consist of Medically Necessary nursing care that is recommended by a designated Participating Physician, approved in advance by the Medical Director, and provided by a licensed home health care agency with which Health Plan has arranged for You or Your Covered Dependent's care and Treatment. These services are available when they are an essential part of an active Individual Treatment Plan, when there is a defined goal expected to be attained and You or Your Covered Dependent are required to remain at home for medical reasons. The designated Participating Physician and Medical Director shall determine the conditions under which all Medically Necessary services shall be provided. Examples of such conditions include, but are not limited to, the following: duration of care; setting, such as inpatient institutional care rather than home care; type of care, such as nursing care or physical therapy; and frequency of care, such as daily or weekly. Home health services shall not be covered for Custodial Care or primarily for convenience, as determined by the Medical Director.

13.2.8 HOSPICE SERVICES

Hospice services consist of Medically Necessary Hospice care that is recommended by a designated Participating Physician, approved in advance by the Medical Director, and provided by a licensed Hospice agency with which Health Plan has arranged for You or Your Covered Dependent's care and Treatment. Medically Necessary inpatient and outpatient hospice services are a covered benefit under this Agreement as specified in the Schedule of Benefits.

13.2.9 MATERNITY SERVICES

13.2.9.1 MATERNITY SERVICES

Maternity services include physician obstetrical care, labor and delivery services, hospital room and board and the care of complicated pregnancies in conjunction with the delivery of a child or children by You or Your

Covered Dependent. Routine deliveries are to be under the care of a Participating Physician at a Participating Hospital.

13.2.9.2 INPATIENT MATERNITY SERVICES

Coverage includes a minimum of forty-eight (48) hours of inpatient care to a mother and her newborn child following an uncomplicated vaginal delivery and ninety-six (96) hours of inpatient care to a mother and her newborn following an uncomplicated delivery by caesarean section, if such inpatient care is determined to be Medically Necessary by a Participating Physician or is requested by the mother.

The determination whether a delivery is complicated shall be made by the Participating Physician. If the decision is made to discharge a mother or newborn child from inpatient care before the expiration of the above time frames, Health Plan shall provide coverage for timely post delivery care, to be provided by a Participating Physician, registered nurse or other appropriate Health Care Professional, and may be provided at the mother's home, a health care provider's office, health care facility or other appropriate location. The mother has the option to have the care provided in the mother's home. The timeliness of the care shall be determined in accordance with recognized medical standards for that care.

13.2.9.3 COPAYMENTS FOR MATERNITY SERVICES

There is no Copayment for maternity physician services. A Copayment is required for each day of inpatient services for the amount and days as stated in the Schedule of Benefits.

13.2.10 FAMILY PLANNING AND INFERTILITY SERVICES

13.2.10.1 FAMILY PLANNING AND INFERTILITY SERVICES

Family planning and services relating to the diagnosis and Treatment of infertility shall be provided as Medically Necessary and as prescribed and authorized by a Participating Physician. Examples of such services include:

- counseling,
- sex education instruction in accordance with medically acceptable standards,
- contraceptive devices,
- placement of contraceptive devices,
- diagnostic procedures to determine the cause of infertility,
- vasectomies,
- tubal ligations, and

- laparoscopies,
- infertility drugs are a covered benefit under this Agreement as specified in the Schedule of Benefits.

**13.2.11 DURABLE MEDICAL EQUIPMENT/
CONSUMABLE SUPPLIES/
ORTHOTICS/PROSTHETIC
MEDICAL APPLIANCES**

13.2.11.1 DURABLE MEDICAL EQUIPMENT

As approved by the Medical Director and prescribed by a Participating Physician, Medically Necessary durable medical equipment may be covered under this Agreement. The Medical Director shall determine the conditions under which such equipment shall be covered. The conditions include, but are not limited to the following: the length of time covered, the equipment covered, the supplier, and the basis of coverage; i.e., rental, purchase, or loan. Health Plan shall provide coverage for these benefits up to the maximum benefit per Contract Year specified in the Schedule of Benefits. Rented or loaned equipment must be returned in satisfactory condition and You are responsible for cleaning and repair required due to abnormal wear and tear or abuse. Coverage for rented or loaned equipment is limited to the amount such equipment would have cost if purchased by Health Plan from a Participating DME provider. Health Plan shall have no liability for installation, maintenance or operation of such equipment for home-based use. This benefit includes diabetic supplies and hearing aids as specified in the Summary of Benefits.

13.2.11.2 CONSUMABLE SUPPLIES

Consumable supplies associated with the use of covered durable medical equipment and prosthetic medical appliances are covered under this Agreement only to the extent that such supplies are required in order to use the specific piece of durable medical equipment or prosthetic medical appliance. Repair, maintenance, and cleaning due to abnormal wear and tear or abuse is Your responsibility. Ostomy supplies, including ostomy tapes, bandages and bags are covered under this section.

13.2.11.3 ORTHOTICS

Orthotics may be covered under this Agreement if determined as Medically Necessary by the Medical Director and if prescribed for a diagnosis of or related to diabetes. Orthotics are intended for repeated use, primarily and customarily used to treat a medical condition covered under this Agreement, and not customarily useful in the absence of a covered illness or injury.

13.2.11.4 PROSTHETIC MEDICAL APPLIANCES

Prosthetic Medical Appliances may be covered under the conditions determined by the Medical Director and as are Medically Necessary to replace defective parts of the body following injury or illness. Prosthetic Medical Appliances are artificial substitutes for missing body parts, such as an arm or leg, used for functional purposes. Health Plan shall cover the initial device, replacements due solely to growth, other Medically Necessary replacements for medical reasons and normal repairs. Health Plan shall provide coverage for prosthetic medical appliances as specified in the Schedule of Benefits.

13.2.12 IMMUNIZATIONS

This Agreement covers Immunizations for You and Your Covered Dependents. Immunizations mean immunizations against:

- diphtheria,
- haemophilus influenzae type b,
- hepatitis B,
- measles,
- mumps,
- pertussis,
- polio,
- rubella,
- tetanus,
- varicella, and
- other immunizations required by the laws of the State of Texas or the United States.

13.2.12.1 COPAYMENT FOR IMMUNIZATIONS

No Copayment is charged for Immunizations for children 0-6 years of age. However, Immunizations are administered and payable for You and Your Covered Dependents 7 years of age and older, as indicated in the Schedule of Benefits.

**13.2.13 BENEFITS FOR SCREENING
EXAMS**

13.2.13.1 Prostate Cancer Screening Exam

You and Your Covered Dependents, if male, are eligible for an annual screening exam to detect prostate cancer. The benefits provided under this subparagraph include the following once per Calendar Year: (1) a physical examination to detect prostate cancer, (2) a prostate-specific antigen test for a male Member who is at least 50 years of age with no symptoms or who is at least 40 years

of age and has a family history of prostate cancer or another prostate cancer risk factor.

13.2.13.2 Colorectal Cancer Screening Exam

You and Your Covered Dependents are eligible for an annual fecal occult blood test. In addition, if you are 50 years of age or older you may receive a flexible sigmoidoscopy every five (5) years or a colonoscopy every ten (10) years.

13.2.13.3 Exam for Detection and Prevention of Osteoporosis

You or Your Covered Dependent are eligible for medically accepted bone mass measurement for the detection of low bone mass and to determine the risk of osteoporosis and fractures associated with osteoporosis.

13.2.13.4 Low Dose Mammography

If You or Your Covered Dependent is a female 35 years or older, an annual screening by low-dose mammography is covered.

13.2.13.5 Cervical Cancer Screening

You and Your Covered Dependents, if female and over age 18, are eligible for a medically recognized annual diagnostic examination, including a conventional Pap smear screening or a screening using liquid-based cytology methods alone or in combination with a test for the detection of the human papillomavirus, for the early detection of cervical cancer.

13.2.14 BREAST RECONSTRUCTION BENEFITS

If You or a Covered Dependent has had or will have a mastectomy, coverage for Breast Reconstruction incident to mastectomy shall be provided under the same terms and conditions of this Agreement as for the mastectomy, as deemed medically appropriate by the Participating Physician who will perform the surgery. Breast Reconstruction means surgical reconstruction of a breast and nipple areola complex to restore and achieve breast symmetry necessitated by mastectomy surgery. The term includes surgical reconstruction of a breast on which mastectomy surgery has been performed under the terms of this Agreement as well as surgical reconstruction of an unaffected breast to achieve or restore symmetry with such reconstructed breast. The term also includes prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy. Once symmetry has been attained, the term does not include subsequent breast surgery to affect a cosmetic change, such as cosmetic surgery to change the size and

shape of the breasts. However, the term shall include Treatment for functional problems, such as functional problems with a breast implant used in the Breast Reconstruction. Symmetry means the breasts are similar, as opposed to identical, in size and shape.

13.2.15 MINIMUM INPATIENT STAY FOLLOWING MASTECTOMY OR RELATED PROCEDURE

Health Plan coverage for the treatment of breast cancer includes coverage of a minimum of forty-eight (48) hours of inpatient care following a mastectomy and twenty-four (24) hours of inpatient care following a lymph node dissection for the treatment of breast cancer unless You or Your Covered Dependent, and the attending physician determine that a shorter period of inpatient care is appropriate.

13.2.16 BENEFITS FOR TREATMENT AND DIAGNOSIS OF CONDITIONS AFFECTING TEMPORO-MANDIBULAR JOINT

Coverage for Medically Necessary diagnostic or surgical treatment of conditions affecting the temporomandibular joint, including the jaw and craniomandibular joint is available to You or Your Covered Dependent, where the condition is the result of an accident, a trauma, a congenital defect, a developmental defect or a pathology. Dental services are excluded from coverage under this Agreement, except for coverage stated under the Dental Benefits and Certain Oral Surgery section of this Agreement.

13.2.17 TREATMENT FOR CRANIOFACIAL ABNORMALITIES OF A CHILD

Coverage for Covered Dependents younger than 18 years, includes reconstructive surgery for craniofacial abnormalities to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infection or disease. Cosmetic surgery is an excluded service to the extent it is not necessary to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infection or disease for a Covered Dependent younger than 18 years. Dental services are excluded from coverage under this Agreement, except as defined in the

Dental Benefits and Certain Oral Surgeries section of this Agreement.

13.2.18 DIABETIC SUPPLIES, EQUIPMENT AND SELF-MANAGEMENT TRAINING

If You or a Covered Dependent has been diagnosed with insulin dependent diabetes, non-insulin dependent diabetes, or abnormal elevated blood glucose levels induced by pregnancy or another medical condition, as Medically Necessary and prescribed by a Participating Physician, You or Your Eligible Dependent are eligible for coverage for Diabetic Supplies, Diabetic Equipment, and Diabetic Self-Management Training under this Agreement.

Coverage for Diabetic Supplies and Diabetic Equipment shall be provided under the prescription drug or durable medical equipment supplies section of the contract with applicable Copayments as noted in the Schedule of Benefits. Diabetic Self-Management Training shall be provided on the same basis as other analogous chronic medical conditions are covered, including, but not limited to the applicable Copayments. Coverage shall also be provided for new or improved Diabetic Supplies or Diabetic Equipment, upon approval of the United States Food and Drug Administration, as Medically Necessary and prescribed by a Participating Physician.

13.2.18.1 COVERAGE OF DIABETIC SUPPLIES UNDER PRESCRIPTION DRUG BENEFITS (AS APPROPRIATE)

Test strips for blood glucose monitors shall be provided according to the copayment levels described in the Schedule of Benefits. Insulin, syringes, oral agents available with or without a prescription, and Glucagon Emergency Kits shall be provided according to the terms of the Prescription Drug Benefit.

13.2.18.2 COPAYMENTS/MAXIMUMS FOR DIABETIC EQUIPMENT AND SUPPLIES

All other Diabetic Equipment and Diabetic Supplies shall be provided according to the terms of this Agreement. You are required to pay Copayments for Diabetic Equipment, Diabetic Supplies, and Diabetic Self-Management Trainings as stated in the Schedule of Benefits.

13.2.19 TRANSPLANT SERVICES

Covered transplants, using human tissue only, if determined Medically Necessary and approved by the Medical Director as not Experimental or not Investigational for the Member's condition may include:

- kidney transplants;
- cornea transplants;
- liver transplants;
- bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease, and Wiskott-Aldrich syndrome;
- heart;
- heart-lung;
- lung;
- pancreas;
- pancreas-kidney.

Donor/procurement costs for covered transplants for matching, removal, and transportation of the organ are covered if:

- 1) the recipient of the organ is You or Your Covered Dependent, and
- 2) the donor/procurement costs are not covered by the donor's Health Benefit Plan.

If the donor's Health Benefit Plan does not cover donor/procurement costs, such costs will be covered.

13.2.20 ACQUIRED BRAIN INJURY

Subject to applicable Copayments, the following services that are medically necessary as a result of an Acquired Brain Injury to You or Your Covered Dependent will be covered:

- Cognitive rehabilitation therapy,
- Cognitive communication therapy,
- Neurocognitive therapy,
- Neurocognitive rehabilitation,
- Neurobehavioral testing,
- Neurobehavioral treatment,
- Neurophysiological testing,
- Neurophysiological treatment,
- Neuropsychological testing,
- Neuropsychological treatment,
- Psychophysiological testing,
- Psychophysiological treatment,
- Neurofeedback therapy,
- Remediation required for and related to the treatment of an acquired brain injury,
- Post-acute transition services; and
- Community reintegration services, including outpatient day treatment services or other post-acute care treatment services.

The reasonable expenses of appropriate post-acute care treatment related to periodic reevaluation on an enrollee who has incurred an Acquired Brain Injury, has been unresponsive to treatment but later becomes responsive to treatment. The Medical Director may determine the reasonableness of a reevaluation based upon one or more of the following factors:

1. cost;
2. time passed since the previous evaluation;
3. differences in the expertise of the Provider performing the evaluation;
4. changes in technology; and
5. advances in medicine.

13.2.20.1 COPAYMENTS FOR ACQUIRED BRAIN INJURY

Copayments for Covered Services for treatment of Acquired Brain Injury shall be the same as the Copayment for the Covered Service most closely resembling the treatment for the Acquired Brain Injury service.

13.2.21 TELEMEDICINE

We will not exclude coverage for telemedicine medical service or a telehealth service under the plan because the service is not provided through a face-to-face consultation. You are required to pay Copayments for Telemedicine as required for other medical benefits.

13.2.22 DENTAL BENEFITS AND CERTAIN ORAL SURGERY

Coverage for dental benefits is limited to dental care necessary to restore and correct Member's "Healthy Natural Teeth" damaged as a direct result of an "Accidental Injury" which occurred while a Member of the Health Plan. Such dental care must be provided within 24 months from the time the "Accidental Injury" and shall not include normal dental Treatment. As used in this paragraph, "Accidental Injury" means an injury caused by an external force or element such as a blow or fall which results in the need for emergency dental care. "Accidental Injury" shall not include biting or chewing accidents. "Healthy Natural Teeth" means natural teeth which are whole or properly restored, without impairing periodontal or other conditions, and which are not in need of Treatment other than Treatment resulting directly from an "Accidental Injury."

Medically Necessary orthognathic surgery, diagnostic, and surgical procedures for the Treatment of conditions affecting the temporomandibular joint (TMJ), including the jaw and craniomandibular joint, and Certain Oral

Surgery shall not be considered dental care and shall be covered under the terms of this agreement as any other physical illness. Certain Oral Surgery means excision of neoplasms, including benign, malignant, and premalignant lesions, tumors, and nonodontogenic cysts; incision and drainage of cellulitis; and surgical procedures involving accessory sinuses, salivary glands, and ducts. Treatment of the TMJ shall be provided on the same basis as diagnostic and surgical Treatment to any other skeletal joint. Oral appliances and devices used to treat TMJ pain disorders or dysfunction of the joint and related structures, such as the jaw, jaw muscles, and nerves, are excluded.

You are required to pay the Copayment for dental benefits for each visit to or by a Health Professional as listed in the Schedule of Benefits. You are required to pay the same copayment for orthognathic and Certain Oral Surgery as required for any other physical illness. You are required to pay the same copayment for surgical Treatment of the TMJ as for other benefits.

13.2.23 AUTISM SPECTRUM DISORDER SERVICES

Coverage for generally recognized services prescribed to enrollees older than two years of age or younger than six years of age diagnosed with Autism Spectrum Disorder, is provided in accordance to a treatment plan recommended by the enrollee's Primary Care Physician.

As used in this provision, "generally recognized services" may include services such as:

1. evaluation and assessment services;
2. applied behavior analysis;
3. behavior training and behavior management;
4. speech, occupational or physical therapy; or
5. medications or nutritional supplements used to address symptoms of autism spectrum disorder.

Autism Spectrum Disorder services must be provided by Participating Provider, which for purposes of this benefit may include:

- a health care practitioner who is licensed, certified or registered by an appropriate agency of Texas;
- a provider whose professional credential is recognized and accepted by an appropriate agency of the United States; or
- a provider who is certified as a provider under the TRICARE military health system.

13.2.23.1.1 COPAYMENTS FOR AUTISM SPECTRUM DISORDER SERVICES

You will pay the same Copayments for the treatment of Autism Spectrum Disorder that are consistent with any other coverage under the health benefit plan.

13.3 OUT-OF-NETWORK REFERRALS

Except for Emergency Care Services, all services under this Agreement must be provided by Participating Physicians, Participating Providers, or Participating Hospitals, unless a referral to a non-Participating Physician, Provider or Hospital is authorized by a designated Primary Care Physician and Medical Director. If a referral is authorized, Health Plan provides services only to the extent such services are covered under this Agreement. Each referral is subject to separate review and approval. For example, an authorization for Treatment by a particular Referral Physician does not also authorize hospitalization in a hospital which is not a Participating Hospital or referral to another physician by the Referral Physician. In cases involving a non-emergency, Health Plan will not cover any expenses associated with Treatments performed or prescribed by non-Participating Physicians, Provider, or Hospitals, either inside or outside of the Service Area, for which Health Plan has not authorized a referral. Complications of such non-authorized Treatments will not be covered prior to the date Health Plan arranges for You or Your Covered Dependent's transfer to Participating Physicians, Participating Providers, or a Participating Hospital. In no event shall Health Plan cover any Treatments which are excluded from coverage under this Agreement or complications of those Treatments.

13.3.1 OUT-OF-POCKET EXPENSES FOR REFERRALS

You are required to pay the same Copayments, as applicable, for referral Treatments as would be required for other benefits provided under this Agreement. For example, if a referral to a non-Participating Hospital is authorized, You will be required to pay the same Copayments and Deductibles, if any, as You would for admission to a Participating Hospital.

13.4 OUT-OF-POCKET MAXIMUM

If the amount of qualifying Out-of-Pocket Expenses You pay during a Contract Year exceeds the Out-of-Pocket Maximum shown on the Schedule of Benefits. Covered Services obtained after reaching the Out-of-Pocket Maximum will be covered at 100% and not be subject to Copayments. Copayments paid under any rider attached ERS 9/2008

to this Agreement, including a Prescription Drug Rider, are not Out-of-Pocket Expenses for purposes of meeting Your Out-of-Pocket Maximum. The Out of Pocket Maximum is \$3,000 per individual and \$6,000 per family.

14. EXCLUSIONS AND LIMITATIONS

The Health Care Services under this Agreement shall not include or shall be limited by the following:

14.1 Abortions

Elective abortions, which are not necessary to preserve Your, or Your Covered Dependent's, health are excluded.

14.2 Altered Sexual Characteristics

Any procedures or treatments designed to alter physical characteristics of You or Your Covered Dependent from You, or Your Covered Dependent's biologically determined sex to those of another sex, regardless of any diagnosis of gender role disorientation or psychosexual orientation, including treatment for hermaphroditism and any studies or treatment related to sex transformation or hermaphroditism, are excluded.

14.3 Breast Implants

Non-Medically Necessary implantation of breast augmentation devices, removal of breast implants, and replacement of breast implants are excluded.

14.4 Chiropractic Services

Chiropractic Services are excluded.

14.5 Cosmetic or Reconstructive Procedures or Treatments

Unless otherwise covered under this Agreement, cosmetic or reconstructive procedures or other Treatments which improve or modify a Member's appearance are excluded. Examples of excluded procedures include, but are not limited to, liposuction, abdominoplasty, blepharoplasty, face lifts, osteotomies, correction of malocclusions, rhinoplasties, and mammoplasties. The only exceptions to this exclusion include certain procedures determined as Medically Necessary and approved by the Medical Director which are required solely because of any of the following: (1) an accidental bodily injury; (2) disease of the breast tissue; (3) a congenital or birth defect which was present upon birth; or (4) surgical Treatment of an illness. As medically appropriate and at the discretion of the Medical Director, any Treatment which would result in a cosmetic benefit may be delayed until such time as You or Your Covered Dependent has completed other alternative, more conservative Treatments recommended by the Medical Director.

14.6 Court-Ordered Care

Health Care Services provided solely because of the order of a court or administrative body, which Health Care

Services would otherwise not be covered under this Agreement, are excluded. This exclusion does not prohibit coverage of a dependent pursuant to a qualified medical support order.

14.7 Custodial Care

Custodial Care as follows is excluded:

- Any service, supply, care or Treatment that the Medical Director determines to be incurred for rest, domiciliary, convalescent or Custodial Care;
- Any assistance with activities of daily living which include activities such as walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking drugs; or
- Any Care that can be performed safely and effectively by a person who does not require a license or certification or the presence of a supervisory nurse. Such services will not be Covered Services no matter who provides, prescribes, recommends or performs those services. The fact that certain Covered Services are provided while You or Your Covered Dependent are receiving Custodial Care does not require the Health Plan to cover Custodial Care.

14.8 Dental Care

All dental care is excluded, except for coverage stated under the Dental Benefits and Certain Oral Surgery section of this Agreement.

14.9 Disaster or Epidemic

In the event of a major disaster or epidemic, services shall be provided insofar as practical, according to the best judgment of Health Professionals and within the limitations of facilities and personnel available; but neither Health Plan, nor any Health Professional shall have any liability for delay or failure to provide or to arrange for services due to a lack of available facilities or personnel.

14.10 Elective Treatment or Elective Surgery

Elective Treatments or Elective Surgery, and complications of Elective Treatments or Elective Surgery, are excluded. Any procedure or therapy undertaken electively by member for cosmetic or other purposes which is without anticipated medical benefit based upon generally accepted medical practice as determined by plan medical director, or for which coverage is otherwise specifically excluded under this agreement. For example, procedures undertaken to alter appearance for purported psychological benefit would be considered elective cosmetic procedures.

14.11 Experimental or Investigational Treatment

Any Treatments that are considered to be Experimental or Investigational are excluded.

14.12 Family Member (Services Provided by)

Treatments or services furnished by a Physician or Provider who is related to You, or Your Covered Dependent, by blood or marriage, or any services or supplies for which You would have no legal obligation to pay in the absence of this Agreement or any similar coverage; or for which no charge or a different charge is usually made in the absence of health care coverage, are excluded.

14.13 Family Planning Treatment

The reversal of an elective sterilization procedure; condoms, foams, contraceptive jellies and ointments are excluded.

14.14 Genetic Testing

Genetic tests are excluded unless approved by the FDA, ordered by a Participating Physician, and approved by the Medical Director.

14.15 Household Equipment

The purchase or rental of household equipment which has a customary purpose other than medical, such as, but not limited to: exercise cycles, air purifiers, central or unit air conditioners, water purifiers, allergenic pillows, mattresses or waterbeds is excluded.

14.16 Household Fixtures

Fixtures, including, but not limited to, the purchase or rental of escalators or elevators, saunas, swimming pools or other household fixtures are excluded.

14.17 Infertility Diagnosis and Treatment

The following infertility services are not covered:

- in vitro fertilization,
- artificial insemination,
- gamete intrafallopian transfer;
- zygote intrafallopian transfer, and similar procedures;
- reversal of voluntarily induced sterility;
- surrogate parent services and fertilization;
- donor egg or sperm;
- abortions unless determined to be Medically Necessary or required to preserve the life of the mother.

14.18 Mental Health

Services for mental illness or disorders are limited to those services described in Mental Health Care and Treatment for Chemical Dependency provisions of this Agreement.

14.19 Miscellaneous

Artificial aids, corrective appliances, and medical supplies, such as batteries, condoms, dressings, syringes (except for insulin syringes), dentures, hearing aids, eyeglasses and corrective lenses, unless covered by Rider, are excluded.

14.20 Non-Covered Benefits/Services

Treatments, which are excluded from coverage under this Agreement and complications of such Treatments, are excluded.

14.21 Non-Emergent Treatment for Non-Plan Providers

In cases involving non-emergent Treatments performed or prescribed by non-Participating Providers, either inside or outside of the Service Area, and for which Health Plan has not authorized a referral, Health Plan will not cover any expenses associated with such Treatments. Complications of those Treatments will not be covered prior to the date Health Plan arranges for Member's transfer to Participating Providers.

14.22 Non-Payment for Excess Charges

No payment will be made for any portion of the charge for a service or supply in excess of the Usual, Customary, and Reasonable charges for such service or supply prevailing in the area in which the service or supply was received.

14.23 Over-the-Counter Drugs

Over-the-counter drugs are not covered.

14.24 Personal Comfort Items

Personal items, comfort items, food products, guest meals, accommodations, telephone charges, travel expenses, take home supplies, barber and beauty services, radio, television or videos of procedures, vitamins, minerals, dietary supplements and similar products except to the extent specifically listed as covered under this Agreement, are excluded.

14.25 Physical and Mental Exams

Physical, psychiatric, psychological, other testing or examinations and reports for the following are excluded:

- obtaining or maintaining employment,
- obtaining or maintaining licenses of any type,
- obtaining or maintaining insurance
- otherwise relating to insurance purposes and the like;
- educational purposes,
- services for non-medically necessary special education and developmental programs,
- premarital and pre-adoptive purposes by court order,
- relating to any judicial or administrative proceeding,
- medical research.

14.26 Refractive Keratotomy

Radial Keratotomy and other refractive eye surgery is excluded.

14.27 Reimbursement

Health Plan shall not pay any provider or reimburse Member for any Health Care Service for which Member

would have no obligation to pay in the absence of coverage under this Agreement.

14.28 Routine Foot Care

Services for routine foot care, including, but not limited to, trimming of corns, calluses and nails, except those services related to diabetes, are excluded.

14.29 Speech and Hearing Loss

Unless covered by a rider, services for the loss or impairment of speech or hearing are limited to those rehabilitative services described in the Rehabilitative Therapy provision.

14.30 Storage of Bodily Fluids and Body Parts

Long term storage (longer than 6 months) of blood and blood products is excluded. Storage of semen, ova, bone marrow, stem cells, DNA, or any other bodily fluid or body part is excluded unless approved by Medical Director.

14.31 Transplants

Organ and bone marrow transplants and associated donor/procurement costs for Your or Your Covered Dependent are excluded except to the extent specifically listed as covered in this Agreement.

14.32 Treatment Received in State or Federal Facilities or Institutions

No payment will be made for services, except Emergency Care, received in Federal facilities or for any items or services provided in any institutions operated by any state, government or agency when Member has no legal obligation to pay for such items or services; except, however, payment will be made to the extent required by law provided such care is approved in advance by a designated Primary Care Physician and Medical Director.

14.33 Unauthorized Services

Non-emergency Health Care Services which are not provided, ordered, prescribed or authorized by a Participating Physician or Referral Physician are excluded.

14.34 Vision Corrective Surgery, including Laser Application

Traditional or laser surgery for the purposes of correcting visual acuity is excluded.

14.35 War, Insurrection or Riot

Treatment for Injuries or sickness as a result of war, riot, civil insurrection, or act of terrorism is excluded.

14.36 Weight Reduction

Weight reduction programs, food supplements, services, supplies, surgeries including but not limited to Gastric Bypass, gastric stapling, Vertical Banding, or gym memberships, even if the participant has medical conditions that might be helped by weight loss; or even prescribed by a physician are not covered.

HEARING AID BENEFIT RIDER

Benefit	Copayment/ Deductible
Maximum benefit payment per ear toward hearing aids every three years.	\$500.00

The Description of Benefits section 13.2.11.2 is modified by adding coverage for hearing aids as described in this rider.

Exclusion 14.19 is modified by deleting the words “hearing aids” and “batteries”.

You or Your Covered Dependent are entitled to receive a Maximum Benefit Payment per ear toward hearing aids as stated above. Replacement hearing aid batteries are not subject to the Copayment or Maximum Benefit and should be submitted as a Claim for reimbursement under this Agreement.

EMPLOYEES RETIREMENT SYSTEM PRESCRIPTION DRUG BENEFIT RIDER

You and Your Covered Dependents shall be eligible to receive prescription drugs on the following basis:

COVERED DRUGS, PHARMACEUTICALS AND OTHER MEDICATIONS

The only covered drugs, pharmaceuticals or other medications (herein collectively referred to as "drug" or "drugs") covered hereunder are those which, under Federal or State law, may be dispensed only pursuant to an order from a licensed physician with appropriate law enforcement agency registrations; which are prescribed by:

- (a) a Participating Physician, or
- (b) in connection with emergency Treatment, a physician in attendance on You or Your Covered Dependent at an emergency facility, or
- (c) by a Referral Physician to whom You or Your Covered Dependent has been referred by a Participating Physician; which are used for the Treatment of an illness or injury covered under this Agreement; or
- (d) filled through a Health Plan Participating Pharmacy in accordance with this Agreement.

As medically appropriate, the Medical Director may require the substitution of any drug for another drug or form of Treatment which, in the Medical Director's opinion based upon the recommendations of the Pharmacy and Therapeutics Committee or expedited review subcommittee, provides equal or better results for less cost. Special dietary formulas for individuals with phenylketonuria or other heritable diseases are also covered under this prescription drug benefit. Heritable diseases are inherited diseases that may result in mental or physical retardation or death. Phenylketonuria is an inherited condition that may cause severe mental retardation if not treated.

COVERAGE FOR OFF-LABEL USE OF DRUGS

Drugs prescribed to treat Your, or Your Covered Dependent's, covered chronic, disabling or life-

threatening illness are covered under this prescription drug benefit if the drug has been approved by the Food and Drug Administration for at least one indication and is recognized for treatment of the indication for which the drug is prescribed in either a prescription drug reference compendium or substantially accepted peer reviewed medical literature. Coverage of the drug includes coverage of medically necessary services associated with the administration of the drug, but does not include coverage for experimental drugs not otherwise approved for any indication by the Food and Drug Administration or coverage for a drug that the Food and Drug Administration has determined to be contraindicated for treatment of the current indication.

EVIDENCE BASED FORMULARY DEVELOPMENT

Health Plan provides coverage for prescription drugs in accordance with an evidence based formulary developed by Medical Group physicians and pharmacists comprising the Pharmacy and Therapeutics Committee. A formulary is a list of drugs for which Health Plan provides coverage at a reduced Copayment. To select drugs to be covered and placed on the formulary, the Pharmacy and Therapeutics Committee reviews at least quarterly the scientific evidence, economic data, and a wide range of other information about available drugs. Based upon that review, the committee selects the drugs it believes to be the most safe and effective of those drugs which meet the desired goals of providing appropriate therapy at the most reasonable cost. Once such determination is made, the Health Plan may contract with the manufacturer of the drugs for discounts for Members. The committee will not select a drug for the formulary until enough clinical evidence is available to allow the committee to determine the drug's comparable safety and effectiveness. The committee determines which drugs to add or delete, supply and dosage limitations, sequence of use, and all other aspects about the Health Plan formulary. When necessary, a subcommittee may conduct an expedited review of a particular drug and make formulary determinations.

REQUEST FOR FORMULARY INFORMATION

You or Your Covered Dependent may contact Health Plan to find out if a specific drug is on the formulary. Health Plan must respond to Your request about the drug formulary no later than the third business day after the date of the request to disclose whether a specific drug is on the formulary. However, the presence of a drug on a drug formulary does not guarantee that Your physician will prescribe the drug for a particular medical condition or mental illness.

FORMULARY LISTS

Copayments vary based upon the Tier a particular drug has been placed in by the Health Plan. Tier 1: drugs on the Health Plan formulary which usually require the smallest Copayment and are generally generic drugs; Tier 2: drugs on the Health Plan formulary which may require an increased Copayment from those reflected in Tier 1 and are generally name brand drugs selected by the Pharmacy and Therapeutics Committee as the preferred drugs in each category on which the manufacturer has given Health Plan favorable value for Members; and Tier 3: drugs on the Health Plan formulary which may require the largest Copayment and are generally non-preferred, or drugs not appearing on the formulary. If a particular drug appeared on the Health Plan formulary at the beginning of Your Contract Year, Health Plan shall make such drug available at the contracted benefit level until the end of the Contract Year, regardless of whether the prescribed drug has been removed from the Health Plan's formulary.

CONTRACTED PHARMACIES

You must use the Scott and White Health Plan (SWHP) Pharmacy or a Participating Pharmacy for the following prescriptions:

- (1) initial and one-time prescriptions;
- (2) medical emergencies; and
- (3) drugs which cannot be mailed safely and legally.

If You have a bona fide medical condition or other legitimate circumstance which makes the refill procedure unreasonable, You may make a request for an exception to the SWHP Pharmacy Director. Requests based solely on preference will not be considered as a bona fide or legitimate circumstance or condition.

AUTHORIZATION REQUIREMENTS

One-time prescriptions which cost \$175 or more and refillable prescriptions whose total cost during a twelve (12) month period could equal or

exceed \$1,000 will require preauthorization by the SWHP Medical Director. Preauthorization must be obtained by the Participating Pharmacies.

EXCLUSIONS

This Prescription Drug Benefit excludes the following:

- (a) drugs which do not require a physician's order for dispensing (sometimes commonly referred to as "over-the-counter" drugs), except insulin;
- (b) anything which is not specified as covered or not defined as a drug, such as therapeutic devices, appliances, machines including syringes, except disposable syringes for insulin dependent Members, support garments, etc.;
- (c) Experimental or Investigational drugs or other drugs which, in the opinion of the Pharmacy and Therapeutics Committee or Medical Director, have not been proven to be effective;
- (d) drugs not approved by the Food and Drug Administration for use in humans or for the condition being treated;
- (e) drugs used for cosmetic purposes;
- (f) drugs used for Treatments or medical conditions not covered by this Agreement;
- (g) vitamins not requiring a prescription;
- (h) any initial or refill prescription dispensed more than one (1) year after the date of the physician's order;
- (i) except for medical emergencies, drugs not obtained at a Participating Pharmacy;
- (j) drugs given or administered to You or a Covered Dependent while at a hospital, skilled nursing facility, or other facility;
- (k) biological products.

REFILL LIMITATIONS

Refill prescription will not be covered until either of the following events occurs:

- (1) You or Your Covered Dependent's existing supply of the prescription will be depleted in less than 10 days; or
- (2) You or Your Covered Dependent's existing supply is less than 50% of the refill prescription amount.

These limitations will be calculated based upon the prescription being taken at the prescribed dosage and appropriate intervals. However, the Pharmacy Director may make exceptions to these limitations for appropriate reasons.

MAINTENANCE DRUGS

In order for a drug to be considered a Maintenance Drug, the drug must appear on the Health Plan's maintenance drug list. If you go to a retail pharmacy to get a maintenance drug, You will be charged the retail maintenance copayment.

MAIL ORDER PRESCRIPTION DRUGS

You may obtain up to a 90-day supply of most covered medications for one copayment per 30 day supply. Your copayment will be based upon the copayment for Tier 1, Tier 2, and Tier 3.

MANDATORY GENERICS

Generic medications will be dispensed unless the medication required does not have a Generic Equivalent. If a Brand Name medication is dispensed when a Generic is available, You will be responsible for the Generic Copayment plus the cost difference between the Generic and the Brand Name medication.

COPAYMENTS

You must pay the Copayment per quantity dispensed per prescription stated in the Schedule of Benefits. The Deductible and Copayments for prescription drugs shall not be subject to the Refund of Excess Copayments provision.

ATTACHMENT 2
SCOTT AND WHITE HEALTH PLAN
SERVICE AREAS AND PROVIDER LOCATIONS
FOR STATE EMPLOYEES

1. SERVICE AREAS

Figure 1 shows the approved Service Area of the Health Plan. Subscribers must work or reside inside of this Service Area in order to be covered by the Health Plan.

Service Area Description:

All of the following counties in central Texas: Bastrop, Bell, Bosque, Brazos, Burleson, Burnet, Coryell, Falls, Grimes, Hamilton, Hill, Lampasas, Lee, Llano, Madison, McLennan, Milam, Mills, Robertson, San Saba, Somervell, Travis, Washington, and Williamson; and, the portion described of each of the following counties in central Texas:

Leon--the southwestern one-fourth of the county bounded on the north by Texas Highway 7 east from the Robertson County line to Texas Highway 75 and bounded on the east by Texas Highway 75 south from Texas Highway 7 to the Madison County line but including the towns of Marquez, Robbins, Centerville, and Leona.

2. PROVIDER LOCATIONS

Following Figure 1 is a listing of the names and addresses of the admitting hospitals in the service area.

ADMINISTRATIVE OFFICES

A1	SCOTT AND WHITE HEALTH PLAN TEMPLE OFFICE 2401 South 31st Street Temple, Texas 76508	A2	SCOTT AND WHITE HEALTH PLAN WACO OFFICE American Plaza 200 W. State Hwy 6, Ste. 300 Waco, Texas 76712	A3	SCOTT AND WHITE HEALTH PLAN BRYAN/ COLLEGE STATION OFFICE 3000 Briarcrest, Suite 422 Bryan, Texas 77802	A4	SCOTT AND WHITE HEALTH PLAN GEORGETOWN OFFICE 204 S. IH-35, Suite 100 Georgetown, Texas 78628
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ADMITTING HOSPITALS

H1	SCOTT AND WHITE MEMORIAL HOSPITAL 2401 South 31st Street Temple, Texas 76508	H7	ST. JOSEPH REGIONAL HEALTH CENTER 2801 Franciscan Drive Bryan, Texas 77802	H13	MADISON ST. JOSEPH HEALTH CENTER 100 West Cross Street Madisonville, Texas 77864
H2	PROVIDENCE HOSPITAL 6901 Medical Parkway Waco, Texas 76712	H8	ROLLINS-BROOK HOSPITAL 608 North Key Avenue Lampasas, Texas 76550	H14	BURLESON ST. JOSEPH HOSPITAL 1101 Woodson Dr. Caldwell, Texas 77836
H3	METROPLEX HOSPITAL 2201 South Clear Creek Road Killeen, Texas 76542	H9	GOODALL-WITCHER HEALTHCARE 101 South Avenue T Clifton, Texas 76634	H15	TRINITY MEDICAL CENTER 700 Medical Parkway Brenham, Texas 77833
H4	CORYELL MEMORIAL HOSPITAL 1507 West Main Street Gatesville, Texas 76528	H10	1021 Holden Street Glen Rose, Texas 76043	H16	LAKESIDE HOSPITAL 3201 Hwy. 71 East Bastrop, Texas 78602
H5	JOHNS COMMUNITY HOSPITAL 403 Mallard Lane Taylor, Texas 76574	H11	LLANO MEMORIAL HOSPITAL 200 West Ollie Street Llano, Texas 78643	H17	THE HOSPITAL AT WESTLAKE 5656 Bee Cave Road Austin, Texas 78746
H6	HAMILTON GENERAL HOSPITAL 400 N. Brown Hamilton, Texas 76531	H12	RICHARDS MEMORIAL HOSPITAL 1700 Brazos Street Rockdale, Texas 76567	H18	SCOTT AND WHITE HOSPITAL UMC 300 University Blvd. Round Rock, Texas 78665
				H19	HILLCREST BAPTIST MEDICAL CENTER 3000 Herring Avenue Waco, Texas 76708